# PUBLIC HEALTH NURSING

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SYPHILIS & [illegible] TOLOGY for NURSES
—by JOHN H. STOKES

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# PUBLIC HEALTH NURSING

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## "VACATION IS A STATE OF MIND"

It may be, but most of us prefer to accompany the state of mind with a state of body. When this magazine reaches our readers, many of you will be knee-deep in vacation, others waist-deep in relieving those on vacation. To suit the reading needs of both groups we are offering a summer number which varies light with heavy reading, which omits the organization departments, and refrains from commenting on professional reading until September! One new venture we hope will be of interest to you all—whether coming or going: the classified information from seven organizations on their procedures in conducting child welfare conferences (page 395). This summary will be continued in September, and, as always, comments from nurses responsible for child health supervision programs will be welcome.

We wish you a happy vacation!

*Rest is not quitting the busy career,*
*Rest is the fitting of self to its sphere—*
*—Dwight*

# Infantile Paralysis After-Care*

By JESSIE L. STEVENSON, R.N.
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THE after-care of infantile paralysis begins when the acute period is over and may continue for months or even years.

The aim of convalescent care of infantile paralysis patients is threefold:

To prevent deformities.
To restore as much muscle power as possible.
To direct the patient's activities in order to help him make the best possible use of the muscle power that he has.

It should be clearly understood that we are working not with that which is gone, but with what we have left. A cell that is completely destroyed can never be restored. However, it is impossible to tell for many months whether a muscle is really lifeless. If there is even a flicker of power, there is a chance that more will return.

If we are to accomplish our aims for the after-care of the infantile paralysis patient, the doctor, the nurse and the family must all work together. It is important that the patient be under close medical supervision from the onset. Whenever possible, it is desirable that the child be under the care of an orthopedic doctor or clinic. The nurse, who carries out the orders of the doctor, may teach the family the after-care. This is a long and slow process and requires infinite patience, cheerfulness, and optimism, as well as technical skill.

### IMPORTANCE OF THE FIRST VISIT

The first visit upon the family of an infantile paralysis patient is a very important one. In Chicago, the visiting nurse makes this visit as soon as the case is reported by the Health Department and while the child is still in the Contagious Hospital. The nurse usually finds the parents beside themselves with anxiety and eager for advice. If this advice is not given until time for the child to return from the hospital, well meaning neighbors have already given advice that is harmful. The first impression is often the most lasting.

First of all the confidence of the family must be won. The mothers have many questions. How soon will my child be well? Will my child always be a cripple? What causes infantile paralysis? Will electric treatments help? They are grateful for the reassurance and advice of the nurse.

The nurse explains that the care of infantile paralysis patients is different from the care of a person who has an acute illness. It extends over a much longer period of time and requires much patience. The child may seem to be well in a few weeks, but his muscles are sick. One of the most important things to stress in the beginning is rest. Rest in bed for many months seems tedious, but it may change the entire future of the child. There are no short-cuts. The slow way is the sure way.

The parents should be told to avoid people who guarantee to cure their child. No one can promise how much muscle power will return. We *can* promise that deformities may be prevented if parent and child will do their part.

### EARLY CARE

When the child returns from the hospital, the first thing to do is to have him seen by a doctor—if possible an orthopedic specialist. In the meantime, simple means may be used to keep the limbs in normal position so that deformities will not develop.

* This article was written with the assistance of the Orthopedic Staff of the V.N.A. of Chicago and was planned to follow the article by Dr. Ludvig Hektoen which appeared in The Public Health Nurse for March, 1931.

Usually the first orders are warm salt baths to relieve the soreness of the muscles and support of the affected limbs by means of simple splints or casts.

One of the best ways to keep the interest of the family is to give them something to do. The father may construct a wooden frame to fit over the tub. A block of wood on the inner edge of one side of the frame will prevent the frame from slipping. A canvas pillow-slip, open at both ends, and just wide enough to serve as a head and shoulder rest, may be fitted over one end of the frame. This enables the child to be in the warm bath more comfortably.

The mother is taught how to lift the child into the tub without hurting or stretching the weak muscles. Muscles that are supported in the splint should not be unsupported when the splint is removed.

### REST

The importance of rest cannot be mentioned too often. It needs to be stressed again and again. Any child who has an extensive involvement of legs and trunk muscles may need to stay in the recumbent position for months. This is more easily said than done. After a few weeks the child feels as well as ever and it taxes the ingenuity of the mother to keep him contented. Sometimes a Bradford frame is advised. If the child's bed can be wheeled through the door, it breaks the monotony to have him changed from one room to another. In warm weather he may be taken out of doors.

One family took the end out of a baby buggy and placed the frame in the buggy. Another ingenious mother constructed a board frame to fit on top of an old baby bed. A discarded mattress was cut down to cover it. Her four year old son was wheeled to the bath room on this portable frame. He spent part of the day on the sun porch. The high frame gave him a vantage point to look down on the world below. This child, who was beginning to be listless and peevish in bed, became happy and contented.

Another mother whose two year old child was on a frame had the head of the frame elevated by screwing a piece of gas pipe into each side of the head of the frame. This was removable so the child could be entirely flat part of the time. The elevated position made it easier to feed her and gave her an opportunity to look out the window.

One father made a portable box bed

*Box bed frame, window height, built for child whose abdominal muscles were extensively paralyzed*

frame which was adjustable. (See picture.)

If a child's arms are not badly involved, bedside games will help to keep him contented. If the mother realizes the importance of rest, she will manage to keep the child in good position.

Rest is also necessary in cases of mild paralysis if the maximum amount of recovery is to take place. One child who was undiagnosed at the onset came into clinic six weeks later, limping badly. The doctor's orders were to keep her off her feet for a month, and to give light massage and exercises to the affected muscles. At the end of a month, the limp was scarcely notice-

able. The program of restricted activity was maintained for several months and the child was dismissed at the end of a year completely recovered.

Even mild cases should be kept under regular observation for a year for sometimes a weakness which has been unnoticed at first will "show up" from over-fatigue. One little girl who was dismissed as a recovered case came into clinic a year later with a tight heel cord, which required the application of a cast to stretch. Upon inquiry, it was discovered that she had been doing a great deal of toe dancing in her gymnasium work at school. The parents' first reaction, as muscle power begins to return, is to urge the child to far too much effort. They are delighted to see that he can ride a tricycle, stand alone or take a few steps without support. They may have been told by neighbors or friends that the child will get well faster by exercise. They reason that if a little is good, a lot is better. It must be explained to them that although the child seems well, his muscles are "sick." To expect a partly paralyzed muscle to do the work of a normal one is just as unreasonable as to expect a child to carry the load of an adult, or to get out of bed after an illness and walk ten miles the first day. Exercise is a good thing but it should stop short of the point of fatigue.

#### GENERAL HYGIENE

*Diet*—The diet should be nourishing and wholesome, laxative and high in vitamines. Cod liver oil may be advisable. Care should be taken that the patient does not become overweight. When it is time to start walking, excessive body weight is an additional strain on already weak muscles.

*Sunshine*—The patient should have as much fresh air and sunshine as possible. Anything which helps to build up generally makes conditions for muscle recovery more favorable.

#### PREVENTION OF DEFORMITIES

It is not possible in a short article completely to cover the topic of prevention of deformities in infantile paralysis. This topic really requires a chapter by itself. It is of course understood that these procedures are followed out only on a doctor's order and under his supervision.

The cause of deformities in infantile paralysis is lack of balance in muscle power. The deformities may be aggravated by malposition. They may be prevented by maintaining the limb in the position of physiological rest. For example, suppose that the muscles which draw the foot up to a right angle are paralyzed, while the opposing muscles which draw the heel back are not. The tendency is for the strong muscles to pull against the weaker. The weaker muscles become stretched while the stronger become shorter and tighter, thus causing a deformity. If the bed covers are allowed to press down on the top of the foot, or if the foot is allowed to dangle unsupported while the child sits in a chair, deformity will develop very quickly. If the foot is supported at a right angle by means of a simple splint, and a cradle is used to keep the weight of the covers off, tight heel may be prevented. It may be explained to the parents that muscles may be compared to bands of elastic. If the elastic is constantly on the stretch, it loses its elasticity. If muscles are constantly on the stretch, they have less chance of recovery. Allowing the muscles to go without rest is just as bad as to allow the child to go without sleep.

*Deformities of ankle joint*—Some of the most common deformities of the ankle joint are:

*Equinus* (tight heel—anterior muscles paralyzed or weak)
*Calcaneus* (drop heel—paralysis of posterior muscles)
*Varus* (club foot position)
*Valgus* (foot turned out—position of flat foot)
A *combination* of one or more of those mentioned.

To prevent drop-foot, the foot should be supported in the splint at a right angle position. A temporary splint may be made of wire mesh, the sharp edges being filed off and the wire bound with adhesive. The splint will be stronger if bound with tin or rein-

forced by wire soldered to the sides and foot piece.

An inner foot piece made of galvanized tin and attached to the foot plate by a coil spring and bolts will allow an additional stretch in either direction. If the heel tends to be tight, it may be stretched beyond a right angle by screwing the bolt near the toe end of the foot plate. If the anterior muscles are stronger and the heel drops, the splint may be extended beyond a right angle by screwing the bolt near the heel. A tendency to varus may be prevented by padding the outer border of the foot piece. Valgus may be prevented by padding the inner border.

#### DEFORMITIES OR CONTRACTURES OF THE KNEE JOINT

*Knee flexion contracture*—This may be caused by allowing the patient to have the knees bent constantly. Knee rolls are not advisable except for short periods. The patient should not be allowed to sit all day with the knees bent. Crawling is harmful. If the splint is long enough to hold the knee in the straight position, a flexion contracture will be impossible. If the patient's trunk muscles are strong enough for him to sit, he should have a wheel chair with adjustable leg extension and foot pieces. If he sits in an ordinary chair the leg should be supported in the straight position.

*Tight knee extensor*—If the child is unable to bend the knee, the knee flexors may be weak but if the mother or nurse cannot bend it to the full limit of motion, the knee extensor (quadriceps) has become tight. This tightness may be caused by having the knee in the straight position all of the time—in a splint or on a Bradford frame. To some extent it is unavoidable and it is certainly to be preferred to a knee flexion contracture. The latter may require casts or surgery, while the former may be worked out by exercises. The knee should be bent gently in the tub each day. The child should bend it as much as possible himself, and the nurse may carry it a little farther, up to the point of pain. Stretching hurts less in the water. The child's knees should be kept in flexion for a part of the time. A wooden trough, built to form an angle, with a foot board may be placed on the frame to hold the hips and knees in flexion for a part of the time. The foot board is to prevent drop-foot in case short splints are not worn. Obviously while one muscle is being protected, care must be taken not to damage another. Positions must be changed from time to time. While one contracture is being worked out, an opposing one may develop. Constant observation is necessary.

*Hyper-extended knee* (knee curved backward)—If the splint is made of wire frame covered by stockinette, it should be shaped to fit the anatomical curve of the knee. If it is made of wire mesh, a felt pad may be inserted just below the knee to support the head of the tibia and prevent backward curving of the knee. Walking without support (of braces or splints) should not be permitted.

*Knock knee*—This may be partly prevented by applying a strap with counter pressure inside the splint. Special attention should be given to exercise of the weak muscles.

#### CONTRACTURES OF THE HIP

Hip flexion contractures are very common in neglected cases of poliomyelitis. They may develop in a very short time from constant sitting or crawling. When they become fixed, only surgical treatment helps. These contractures may be prevented by keeping the hip in extension. A patient unable to walk should not spend long periods sitting or propped with many pillows, particularly if the hip flexor muscles are stronger than the extensors. He should lie on his face for a part of the time each day. If the contracture has already begun, sand bags may be placed on the buttocks to stretch the muscles. (Care should be taken while the patient is in this position to protect the ankles so as not to cause drop-foot. This may be done by bending the knees and supporting the feet at a right angle by means of pillows or sand bags.)

*Hip extension contractures*—If the hips are kept in the straight position all of the time, the glutei (hip extensors) may become tight. This can be determined by passively bending the patient's hip. If the movement cannot be completed, the extensors are tight. In order to make sure that it is the hip, not the knee, the hip should be bent with the knee supported in the straight position. A hip extension contracture is far less serious than a flexion contracture and may be avoided by keeping the hips in the position of flexion for a part of the time. This may be done with the knees bent or straight. Daily manipulation should be performed in the warm bath.

*Contracted outward rotators*—The hips will become contracted in the position of outward rotation if the legs are allowed to roll outward. Unless the patient is carefully watched, this may happen when the legs are in splints or in plaster casts that do not include the hip-joints (spica). This will prove a serious handicap and cause an awkward gait in walking. It will also occur if the child sits in the frog leg position. Splinted legs may be kept from rolling outward by fastening the inner edges of the splints together with a safety pin. Another method is to tie the knees together. If the child is small, a tongue depressor, secured to the base of the foot piece at a right angle with adhesive will give a wider base and not allow the leg to roll out so easily. A piece of heavy cardboard or light wood may be attached to the splint of an older patient, in a similar manner.

### TRUNK WEAKNESS OR WEAK ABDOMINAL MUSCLES

If a patient cannot sit erect without bulging of the abdomen, or maintain his balance in the erect position without swaying, his abdominal muscles are weak. If the muscles are evenly paralyzed or weakened, the abdomen will protrude and the back will appear hollow. If the muscles on one side are stronger, the patient will sway to the strong side, thus stretching the weak side. Lack of balance of muscle power of abdominal muscles is a serious condition for it causes spinal curvature.

A patient with abdominal weakness should not be allowed to sit without support. It is best to keep him in a recumbent position. This may be done on a Bradford frame or if he is lying in bed, the mattress should be smooth and firm and not allowed to sag. A piece of beaver board may be placed under the mattress.

If the lateral abdominal muscles are weaker on one side, the patient's bed should be placed in such a position that he will have to exercise the weak muscles by bending toward that side. If there is no lack of balance, the position should be varied, so that the patient will get an equal amount of exercise. If the leg on the side of the weaker abdominals is kept in abduction part of the time, the lateral muscles will be in a position of greater rest.

Stretching the weak muscles should always be avoided. When the patient lies on his face, a small pillow placed under the abdomen will prevent stretching of the abdominal muscles.

A crooked back can nearly always be prevented but it can never be wholly cured. If the parents persist in allowing the child to sit or stand without support, the nurse may show them pictures of children with bad spinal curvatures that have developed from neglect. It is cruel to frighten a mother, but as a last resort, it may be necessary.

### DEFORMITIES AND CONTRACTURES OF THE ARMS

The arm muscle that is most frequently paralyzed is the deltoid which lifts the arm to shoulder level. Possibly more than any other muscle this can be damaged from lack of support. If the arm hangs down at the side, the weight of the arm and gravity will cause the muscle to become stretched and the arm to become useless.

The arm should be kept at shoulder level twenty-four hours a day. If the child is in bed, the arm may be tied to the head of the bed by a loop bandage, or the sleeve may be pinned to the side of the crib. As soon as the child is allowed to sit, a splint or brace should be provided. If he does not have a splint, an extension may be built on the

arms of the high chair which will allow movement of the arm at shoulder level only. An inexpensive splint may be made of ordinary heavy wire, covered with stockinette. This may be bandaged on or attached to a canvas girdle with tapes and buckles.

If the child's elbow tends to become contracted while wearing the brace, the brace may be removed at night and the elbow placed in the straight position. Or, it may be possible to adjust the brace so that the elbow will be in partial extension. A contracted biceps is not nearly so serious as a stretched deltoid.

Do not promise that the brace will cure the arm, but say that it gives a chance for better recovery of muscle power.

#### CONTRACTURES OF ROTATORS OF SHOULDERS

If the shoulder is constantly in the position of outward rotation (position required to place hand back of neck), it will become tight in that position and it will be impossible to complete the movement of inward rotation (movement required to tie apron in the back). The position should be varied so as not to allow tightness in either direction.

#### DEFORMITIES OF WRIST AND HAND

The two most common deformities of wrist and hand are:

A subluxation of the thumb caused by a paralysis of the muscle which draws the thumb to the opposite side of the hand.

Claw hand—the result of a paralysis of the muscle which both bends the first joints of the fingers and holds the second and third joints in the straight position.

Use of the thumb is of great functional importance in grasping objects. The thumb may be bandaged to the opposite side of the hand, taking care that pressure is placed on the first joint.

A splint to prevent claw hand should hold the first joints of the fingers in the bent position and the second and third joints in the straight position.

*Wrist-Drop*—Wrist-drop may occur if the muscles which hold the wrist straight are weaker than the flexor muscles. It may be prevented by holding the wrist in extension or hyperextension. The "cock up" splint should be shaped to fit the arch of the hand so that the palm will not flatten out.

#### MASSAGE

Massage should not be started until all soreness has disappeared. Heavy massage given too soon, not only prolongs muscle soreness, but may result in actual injury to the weakened muscles. The purpose of massage is to improve the circulation, thus assuring better nutrition for the muscles. Heat should precede the massage. A warm bath may be given, or a hand baker or bathroom heater used. (Paralyzed muscles are easily burned for they do not feel intensive heat as quickly as do normal muscles.)

#### MUSCLE TRAINING

*Exercises for infantile paralysis patients should be given or taught by specially trained people.* They may be given in water and on the table. If they are given in the home, an ordinary kitchen or dining room table will suffice. When the doctor says that exercises may be started, a careful muscle examination should be made to determine which muscles are weakened. Carefully graded exercises are then worked out to suit the strength of the affected muscles. Exercises improperly given do more harm than no exercise at all.

In Chicago, visiting nurses who have had special training in physiotherapy give home treatments to new patients three times a week for the first year if the involvement is extensive. The mother is expected to watch throughout the treatment and is taught slowly both to help and to give the entire treatment: bath, massage and exercises. As the mother becomes more proficient, she gives the exercises as a demonstration before the nurse. Then home visits are made less frequently. It must be explained to the mother that the fact that the nurse does not come so often does not mean that the treatments are less necessary. There are never enough nurses to give the needed exercises daily.

At first it is necessary to concentrate on the return of as much muscle power as possible. Later on it is even more important to teach the patient to make the best possible use of the power that he has. Any person is more independent and less trouble to his family if he can perform the following actions without help:

1. Sit up when lying down.
2. Stand up when in a sitting position.
3. Sit down (or reverse of 2).
4. Walk (maintain balance).
5. Climb—if only one step (as over a high door-step) or up or down one step at a time.
6. Use one or both arms to comb hair, perform necessary toilet functions, dress and feed himself.

The normal person has no conception of the added usefulness and satisfaction that is given a patient who through muscle training becomes able to do some of the above actions without other personal aid. Braces, canes and crutches do not necessarily make a person dependent on others.

#### ECONOMIC AND SOCIAL ASPECTS

The question of apparatus for infantile paralysis patients cannot be considered independently. Apparatus is worn to prevent deformity and to make walking possible. While the patient is in bed or in a wheel chair, inexpensive apparatus may be devised. When he is ready to walk, stronger braces are necessary. These are expensive. A short brace may cost from $15 to $25 and a long brace from $25 to $50. These must be replaced at least every two years for a growing child if he continues to need the braces. This is a factor to be considered in the budget of a family of moderate means.

The parent's first reaction is—"Won't the brace stop the circulation?" "Will it make the leg thinner?" Suppose this were true, the answer is that the alternative is worse. The circulation may be helped by massage, warm baths and exercises. Parents should be warned that the paralyzed leg probably will become a little thinner but it does not come as a result of wearing the brace and it is not a subject for worry.

Small children soon become accustomed to wearing apparatus and are contented and happy. They live in the present and have no worries for the future. The problem of apparatus for the adolescent boy and girl is very different. An arm brace is particularly conspicuous and the child is extremely sensitive. The answer to this problem may be the special school or convalescent home.

Most families tend to pamper the handicapped child. They should be taught that self-reliance is his most precious possession and they should do nothing to destroy it. He should wait upon himself in so far as he is able. The more he can do for himself without damage to his muscles, the better it is for him mentally and physically. He should never be referred to as a cripple.

Care of the handicapped is a community problem. It includes physical care given through dispensaries, hospitals, convalescent homes, and public health nurses. Physical care must go hand in hand with education given by special schools or special classes in public schools. For the more severely handicapped, vocational guidance, training and placement may be necessary. Every public health nurse should know the resources of her state and community in meeting these needs.

# All in the Day's Work

By FRANCES E. WHITE
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WELL, well—9 A.M. Look at that notebook! Ten calls that must be made and at least four more to sandwich in, if possible. Have I got everything?—Bottle full of soap, instruments and scales properly placed, tongue depressors, thermometers, plenty of paper napkins, two recipes for senna prunes and four lists of supplies for prenatals. For once I've remembered everything.

Voice from front of room: "Oh Miss White—you've forgotten the layette for the Smith family."—What would we do without the girl at the typewriter!

Let me see, where do I go first? A bath for Mrs. Jones who has had an acute attack of an old gall bladder trouble, and who has the added complication of being very deaf. Conveniently near the door is a pile of papers, fresh linen is warming on the back of a chair over the register, bath blanket over the foot of the bed. From the bathroom issues a voice—"The towel and soap are in here and the alcohol is warming in that basin of water." What a perfect beginning to a busy day! Then to the routine work—soap out of the bag—hands washed—paper napkins spread on a convenient place and out comes my basin and towel—thermometer — cotton — applicators — an extra napkin. I slip on my apron, meanwhile keeping up a conversation with the patient's daughter who is standing in the bathroom and trying to include Mrs. Jones, who in spite of her defective hearing loves to be included in any conversation even though she doesn't get the point.

Then temperature, bath quickly over and warm fresh linen in place. "Miss White—do I look better today?" Much vigorous nodding and motioning on my part. "Miss White—do you suppose I have a cancer?" I scowl and shake my head—a look of relief appears on her poor old face. "Well—I believe I feel better myself."

Then all the soiled things picked up, hands washed, thermometer cleaned and bag quickly repacked and I am again on my way. But there is the daughter waiting for me at the door—"Now Miss White, you are a nurse and I feel that I can speak frankly. Do you think the Doctor is doing everything for mother that he might? What do you think is wrong with mother? Miss White, tell me, what do other patients think of Dr. ——? Can you tell me what else to give mother for nourishment?" She already has a list from the doctor. What a life! Trying to say exactly the right thing, trying to get away repeating—"Do as your Doctor tells you" and at last, in desperation, saying goodbye while she is still talking—and hoping not to be rude...

Next a prenatal patient—and a problem! The husband has been out of work for eleven months with only an occasional day's work. Seven children ranging from the age of 17 years down to 4 years. A girl of fourteen years, mentally defective, another child, a boy of twelve distinctly feeble minded, and now another baby to think about. So many things to do—I list the steps in my mind: Hospital arrangements to be made, a free bed, of course—every penny in this house needed for food for seven hearty appetites—assuring myself that the oldest girl is capable of caring for the younger children while the mother is in the hospital; arranging for the mentally defective child and the feeble-minded boy—why have they been left at home all this time?

In the home I go through the usual prenatal routine: temperature and pulse fine, general condition good—We discuss minor aches and pains, go over

the list of supplies. I find the mother has nothing for the new baby. I explain about the layettes at the Associated Charities and suggest that she go there on her way back from the hospital where she is to go to complete her delivery arrangements. She is pitifully eager to do all she can in the way I think best and grateful for the help I can give her. During our conversation there have been intermissions of removing inquisitive little fingers from my bag, moving a sticky small boy from the back of my rocker, giving a little girl advice about her doll's dress, and listening to the inhuman squeals and mouthings from the girl in the corner as she aimlessly fingers a piece of bright cloth. I discover that for three years Mrs. G. has had papers committing the two children to the State institution but each time she has appealed for help at the Court House, she has returned discouraged. The boy sits on the floor talking and laughing to himself, picking out the names of animals he has learned from a picture book. Special classes would do much for this child—he could be useful with his hands. He is twelve years old and no one has done anything for him in the line of education. A teacher came once and told the mother he needed special training, an investigator called and said something ought to be done, and now I tell her I'll see what I can do! She doesn't look very hopeful—I can readily understand what she is thinking.

So to the Court House. I explain about the children—no one seems to remember them. Then a final "There's nothing we can do Miss White, the institution is impossibly crowded now, many of the patients listed here have been waiting five years for admission." Special classes are suggested for the boy—a fine idea if one is able to find some person who will do it. Here is work for another day.

And now to the home of my newest post partum. Here is my big achievement. The father is 20 years old, the mother 19. No work for months but there has been boundless enthusiasm on the part of both. The little bed room is filled with evidences of coöperation. Somewhere a bed for the baby had been discovered for the sum of fifty cents—rickety and unpainted. Now it stands solidly, gleaming, ivory finished trimmed with touches of blue. Two bright patch-work quilts made by the young mother are drawn snugly about the son of the family. Nearby is a distinctly original baby tray. Instead of the usual tray the mother took a stand, painted it to match the bed and around the top fastened cretonne in such a way that it makes numerous pockets. Each pocket contains a jar with the necessary article in it and a pocket for the pins. On top are a blue and white basin and the soap dish, underneath towels and wash cloths. We are very proud of this, feeling it a real achievement. In another corner is a little white box filled to the brim with beautifully-laundered, little garments. No brand new material touches this baby's skin. The nurse said they should be washed first and explained why and so they were washed!

In the lower drawer of the dresser I know there will be a fresh gown, a change of bed linen and two towels—washed out and ironed since yesterday—this young father is proving to be quite a housekeeper. A cheerful "good morning" greets me from the bed—"Miss White, my cousin just left and was very angry because I wouldn't let her rock the baby. She didn't like it because the binders were off me—said I would be sorry. But you know I decided that I couldn't listen to both of you, so I decided to listen to you." What sweet music to a nurse's ears!

On with the bath—paper bags already made. Table all fixed for the baby's bath. The husband bustles in from the kitchen with the water, the bath is quickly given, the baby weighed. Then in a proud tone to his wife: "Mary—he's gained a quarter of a pound," and in the next breath, "Miss White, can Mary have anything she wants to eat?" There follows a discourse on foods. I point out some chapters in the baby book to be read.

Everything settled—baby contentedly drinking warm water. A last earnest question from the husband: "Miss White do you think it would spoil him if I held him for just a few minutes after he nurses? I kinda like to." Well—what would *you* say?

And now well babies to be weighed. The first stop in an old tar paper shack, the yard littered with parts of old cars, boxes and refuse of every description. Inside unspeakable filth and squalor—crawling things on the walls—no paper for my bag. Out come two more paper napkins. Grandmother from her seat beside the rusty stove watches my preparations disdainfully. She inhales deeply from the cigarette she is smoking, blowing a cloud of smoke through her nose while the infant on her lap squirms and cries fretfully.

The mother appears from a bedroom—hair uncombed and looking very much unwashed generally. She raises her shrill voice "John, Miss White wants some water for her hands." An outburst of profanity is the reply. Grandmother reminds him that there are ladies present. Finally, water makes its appearance, I slip my scales into the pocket of my uniform and look about for a place to weigh the baby. Bed?—absolutely not. Rocker? No better. I finally decide on grandma's ample lap. Wonder of wonders—the baby's clothes are all fresh and clean. My spirits lift a little. Maybe I am making an impression. These people do not believe in changing a baby's clothes every morning. The baby has gained a whole pound. I finally discover that it is being fed on the average of every one and a half hours. In dismay I again attempt to impress upon my listeners the points in favor of a three hour schedule. Grandmother favors me with a superior sniff—very evident that she rules this house. The mother tries to absorb the idea—rather unsuccessfully. I console myself with the thought that anyway the baby is clean and in another week I may be able to win grandmother's confidence—something to look forward to. I pull on my coat praying that somehow I may in the end be able to influence the old woman behind the stove.

Oh the marked contrast of the next home! A healthy cooing baby, taking its cod liver oil without a protest, gaining its half pound a week, sweet, clean, normal.

I stop at Evelyn's to inspect the fit of her new glasses. Her round blue eyes look straight at me. No longer does that right eye swing in, no more squinting when she reads—a grateful mother. I depart thanking the powers that be for making such welfare work possible.

So through the day. I glance at my watch—4:30 already! I must hurry, to get back to the office, panicky with the sudden thought—"I forgot to put down the number of John Hancock cases on my daily report sheet!" Maybe, this once, the secretary did not notice it.

I was wrong. She did!

*Editor's Note:* Miss White, our diarist, has been awarded the Michigan State Nurses Association scholarship for 1931 and enters the University of Michigan in September for a year's course in public health nursing.

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**BUDGET REPORT READY**

The Budget Council report, "Budgeting the Low Income," issued by the New England Home Economics Association, with the revised prices as of June 1, 1931, is now ready for distribution. Single copies are 45¢ by mail and may be secured from Blanche F. Dimond, Community Health Association, 502 Park Square Building, Boston, Mass.

# Itinerant Public Health Nursing Under the American Red Cross*

By CALISTA L. CROWN

American Red Cross Nursing Field Representative, California and Arizona

WHEN we see the rapidly expanding health work in the cities and prosperous rural communities we sometimes feel that the time has come when health protection is considered essential along with other educational advantages. At first we may think that the hundreds of counties without any kind of public health nursing are simply unprogressive in thought and action. But if we visit some of these communities and see what struggles they have to provide even the semblance of an educational system, we realize that here is a need that is beyond their power to meet regardless of how enlightened they may be.

The Red Cross through its many rural Chapters has seen the health needs of these areas and in 1923 devised a plan for serving these people. This scheme was first tried in the southwestern states and became known as the itinerant public health nursing service. It proved so popular that twenty-five Chapters availed themselves of this service the following year, and the number has gradually increased until the service was given to eighty-one Chapters in twenty-five different states last year, including the eastern and Pacific areas as well as the midwestern where it is extremely popular.

Under this plan the American National Red Cross employs the nurse on a yearly basis and makes contracts with the Chapters to use her for a definite period of time, usually three or four months. The Chapter reimburses the National for the salary of the nurse during the time she is employed and also assumes responsibility for incidentals and for her transportation within the Chapter jurisdiction. The National office is responsible for vacations, sick leave beyond two and one-half days per month and transportation to and from the Chapter territory. Financial assistance may be secured from public or private agencies if Chapter funds are limited but in any event the Chapter signs the contract and is responsible for the service.

The Delano Memorial Fund is used to help some communities too poor to pay the salary of the nurse for even a short period. When Jane Delano died she left $25,000 as a memorial to her father and mother to be used for furthering public health nursing in isolated communities. In the beginning this fund was used to employ nurses on a yearly basis, but during the last few years the committee responsible for its disbursement has felt that more communities could be helped by putting it on an itinerant basis. This assistance is given to those Chapters which have an interested and active committee who expect to carry on the service year after year. The Chapter pays a small part of the nurse's salary the first year, increasing this amount each year until it is able to assume the entire cost. As in every itinerant service, an active committee is essential.

### PIONEER WORK

The itinerant public health nurse is frequently a pioneer health worker in the community which she serves, although she may be employed for a special project such as a home hygiene program in communities where other nurses are working. Ideally this service should be given to a small town or rural section where distances are not

* Presented at the joint meeting of the California State Organizations of Nurses, Yosemite National Park, June 2, 1931.

too great. However, since the Chapter sponsors the program it is usually necessary to serve the Chapter jurisdiction whether that be a county or a town. If the county must be served, it is possible to divide it into sections concentrating on a different section each year until all have had the service.

The type of work carried on varies with local conditions. In practically every service classes in Home Hygiene and Care of the Sick are given because the benefits derived carry over after the nurse has left, and because they arouse community interest in public health. Frequently the service centers about the school children because they are easier to reach. Other possibilities are a program centering around the baby and pre-school child or a community program such as immunization or improvement of sanitary conditions.

Getting the contracts in on time constitutes one of the greatest problems of the itinerant service. Chapters seem to feel that the nurse can be delivered upon receipt of a contract, much as they receive goods from a mail order house. In order to know how many nurses must be employed and in order to arrange their itineraries economically, it is important that all contracts be in before the beginning of the year. Another difficulty is that of transportation. This has been solved in the eastern and midwestern areas by having the nurse own her car. In the Pacific area this has not seemed feasible because of the great distances to be covered. Here transportation is arranged by the Chapters. Various arrangements are made such as renting or purchasing a car or depending upon volunteers and public carriers.

The itinerant service is not designed to take the place of a full-time service when the latter is possible. Until itinerant nurses were available, communities which could not afford a continuous service either went without or saved their money until they could employ a nurse for a year or two, then dropped the work. In this way much of the value of the nurse's work was lost and the effect upon the community was discouraging. On the contrary, the itinerant service has a stimulating effect upon the community and usually results in a determination to continue the work year after year and work toward an increase in time and a continuous service.

Someone may ask, "Does the itinerant service satisfy the community and thus interfere with the establishment of a full-time program?" The answer is emphatically "No". In the first place, there are many counties which do not have the resources to conduct a full-time service and will not have them for years to come. Others, which could afford the financial support if they could once be convinced of its need, will learn the value of the work much more quickly by having an itinerant service than by having no work at all.

The first thought which comes to the mind of the public health nurse who is unfamiliar with the itinerant service is apt to be: "How can a nurse do an effective piece of work in three or four months when it usually takes nearly that long to become acquainted with a community and its resources when starting a new job?" She learns to adjust herself quickly to new circumstances and if she is working year after year in the same state or states she becomes familiar with general conditions. Facts about the particular community she is to serve are obtained by the field representative before the nurse starts. A letter goes to the Chapter suggesting preliminary plans to be made and supplies to be ordered. This letter is not always effective as the Chapter is apt to wait until the nurse arrives. The delay seldom happens more than once as the people are quick to realize the time that is wasted if these instructions are not followed. The committee, prompted by the field representative, generally has a very good idea of the type of work it wants done and is ready to meet with the nurse on her arrival to help plan the program.

### SPEEDY RESPONSE

During a four-months' itinerant service, a nurse can do more than one-third

as much as the average nurse can in a year's program. In case you may think my arithmetic wrong, let me explain the reasons for this. In the first place she can get volunteer assistance more easily. The citizens seem to have a much clearer idea of the value of the nurse's time when she is with them for only a few months than when she is employed by the year. To most of these people the salary of the nurse seems enormous and they value her time accordingly. It is not hard to show them that it is costing them money for a nurse to spend half a day on clerical work that could be done by a volunteer. In addition to the saving of money the people realize that the nurse will be with them for only a short time and they are anxious to see her at work. This makes it easy for her to get response when she asks someone to work with her at the school. The use of volunteers during inspections not only serves the purpose of conserving the nurse's time but also interests the volunteers in the conditions in the school and the need of health education in the community. When the nurse invites the parents to come to the school on certain days to see her they take advantage of this opportunity because they know they will not see her if they procrastinate. In contrast to many committees which seem to feel that the time spent on records should be kept at a minimum, the committee responsible for the itinerant service displays great interest in the record work and wants to make sure that it can interpret the records after the nurse has gone and that the next nurse will be able to carry on.

Another reason for greater accomplishment in this short period is the fact that the nurse can concentrate on actual preventive work. Many boards of education still feel that the school nurse should spend the greater part of her time doing minor dressings, taking temperatures, etc. The itinerant nurse meets no opposition when she spends her time teaching the teachers to do this work, and to recognize symptoms of communicable disease. The teachers take more responsibility and try to learn all they can from the nurse during her stay, instead of depending upon her to solve their problems as they are apt to do when she is with them all of the time.

A third reason for the effectiveness of the itinerant service is the effect upon the nurse herself. Whereas a definite program of work is equally necessary in any public health nursing service, the results of poorly planned work are more directly evident in an itinerant service. The full-time nurse sometimes excuses the lack of a definite program on the grounds that she has to "take things as they come". For the itinerant nurse to do this would be disastrous. She must actually accomplish something during her stay or the contract will not be renewed. In addition, she must let the people know that she has accomplished something, and this involves good publicity. She must also make sure that her work is going to carry over after her departure. The only way to accomplish these aims is to make a definite program of work not only for the months but also for each week, each day and one almost might say each hour. And yet this plan must be flexible in order to allow time to meet emergencies as they arise and to respond to requests for talks to various groups. The nurse must overcome whatever dislike she may have for public speaking as it is absolutely necessary for her to put her work before the people in this way. The itinerant nurse always wears the complete Red Cross nurse's uniform and this alone reminds the people of the service the Red Cross is giving their community.

From the standpoint of the nurse, the itinerant service affords excellent experience in program planning, organization of committees, use of volunteers, and publicity, as well as a varied experience in the type of work done. However, the nurse who must be stimulated by congenial professional associates or who needs to be able to relax in a room surrounded by her own pictures, books, and other personal possessions, should never attempt this

work. She should be able to content herself among strangers and be equally at home in a steam heated hotel, a private home without any conveniences or doing her own cooking in a cabin. She must be a good automobile driver and not afraid of lonely mountain roads. In addition to this she must be physically able to carry a heavy program of work and to adjust herself to varied altitudes and climatic conditions.

The word "itinerant" has never appealed to me. It savors too much of box-cars and Model-T Fords. During a recent visit to Yosemite it occurred to me that we might borrow a name from the rangers. Those of you who are familiar with the terminology used in the National Parks know that the rangers who are on duty all the year are known as the "Old Timers". What better name could we find for the itinerant nurses than that given to the rangers who are here for the summer months only—"Ninety-Day-Wonders"?

# A County Health Advisory Committee

By JOHN W. WILLIAMS, JR., M.D.

Field Agent, U. S. Public Health Service—County Health Officer, Springfield—Greene County Health Department, Missouri

THE establishment of a full time County Health Department in Greene County began in February 1925. This full time Unit was begun as a combined organization with the Springfield City Health Department. The funds were all derived from official sources, the Federal, State, County and City governments being the participating agencies. The control of all the programs and policies of the Unit was vested in an Executive Committee made up of the three judges of the County Court, three City Commissioners and three members of the Medical Society, the executive head of the unit being the County Health Officer. This basic plan has been strictly adhered to.

### SOMETHING MISSING

After one year of work it became evident that there was something wrong with the organization. The Executive Committee was operating perfectly, meeting each month for a review of the work and a consideration of any new program suggested. Yet even with this support from the sources of funds it was plain that the work was not understood by many people outside the Unit. It began to be apparent that the organization was on the border line of failure unless something could be done to get a first-hand knowledge of the activities to more people who would render support either through creating a more favorable public opinion or through political support. At this time no information was available of other organizations functioning in such relationship to a Health Unit. A tentative plan for a larger committee to assist the Executive group was therefore outlined. This plan was built up around certain people who held offices which placed them more or less in contact with the Unit's work. The Superintendents of City and County Schools, the Secretary of the Red Cross, President of the Tuberculosis Association and the President of the City and County Council of the Parent-Teachers Association were invited to meet as an Advisory Committee. After several months trial it was found that even this group could not carry the work very far.

### APPEAL TO THE LAYMAN

Building on this past experience, the organization of a much larger body of lay people was begun. An invitation was sent to about twenty-five rep-

resentatives of many organizations in town, and to community leaders in the County asking them to meet with the Health Department. Some thirty attended this meeting without knowing its object. The County Superintendent of Schools explained to this group the need for health promotion and asked their aid in all the programs of public health and their support in the activities of the health department.

The next step in organization was the selection of fifty-five representative people who could be relied upon to help. Each name was considered carefully and approved by the Executive Committee. This approval of members was resorted to in order to exclude any trouble makers and to make membership something not easy to obtain. Each person approved was then sent a letter explaining what the organization was, advising that he (or she) had been selected for a place on the Committee and enclosing an acceptance of the obligation to be returned to us. From this group we received about 95 per cent favorable replies.

A meeting of all the Committees was then called to be held in the Health Department offices with luncheon served at noon and a program to follow. The roll call at this meeting showed seventy present instead of the fifty-five invited! A set of by-laws was read and adopted and after a short musical program and a report of the work done that month, the meeting adjourned to meet thereafter on the second Monday of March, June, September and December.

This large unit functioned well but after a year it became evident again that something was amiss so that at the next meeting the by-laws were amended to read that this Committee be known as the Coöperative Committee, its chairman and vice-chairman to be elected by them from their own membership. It thereby became an organization within the Health Unit.

#### FRIENDLY ADVISORS AND PUBLICITY AGENTS

This Committee has continued to function each quarter. Committee members from various communities in the County have invited the group to meet with them so that it has become a county-wide community organization. Last year a member moved from the County and immediately a dentist in that town asked for his place on the Committee. The members feel as though they are a working part of the Department, knowing first hand what is being contemplated and done. This intimate knowledge of the character and scope of the work has made it possible for these people to get the health program more widely spread throughout the community, and the economic importance of public health brought more directly home to their friends and neighbors than could have been possible under any other method.

After four years of this work the membership still contains seventy-five per cent of the original group and is made up of lawyers, doctors, dentists, ministers, community and organization leaders from all parts of the County. It has been the policy to have the kind of program at each meeting of the Committee that would be interesting and worth the time expended. The group is always served a luncheon, prepared by the nurses before each meeting, so that this time may be used for friendly visiting. It is common for members to bring as many guests to the meeting as there are members because they feel that it is well worth while to be there, visiting, gossiping, eating and working to spread the gospel of public health.

# Tuberculosis Nursing*

By ELIZABETH HANSON
Tuberculosis Supervisor, Visiting Nurse Association, Hartford, Connecticut

LET us consider tuberculosis nursing from three points of view: What tuberculosis nursing is; what the nurse needs to know about the disease itself, and the useful techniques applicable in nursing it.

### WHAT IS TUBERCULOSIS NURSING?

Is there really such a thing as tuberculosis nursing? It is not an entity; it cannot stand alone; it is so closely tied up with the other phases of public health nursing that it cannot be considered apart from these other activities. Our tuberculous patient may become a prenatal, and prenatal care must be given. Bedside care may be needed, and bedside nursing must be considered. And of course tuberculosis must be viewed always as a communicable disease. Likewise, if within the family circle there are infants or preschool children, infant and child health work becomes part of the program. If there are school children or employed adults, school nursing and industrial nursing become possibilities. If the visiting nurse, herself, does not carry this entire program, she coöperates so closely with the school and industrial nurses, that the picture becomes truly composite. Consequently, we see "tuberculosis nursing" as one aspect of public health nursing rather than a separate entity, but one, nevertheless, which holds a very vital place in the general program.

On April first, 1928, the Hartford Visiting Nurse Association generalized its services. Since 1928 there has been an increase in the number of tuberculosis cases carried from 387 to the 521 carried in the last three months of 1930. Contact cases for the same period increased from 171 to 1,188. Need we ask, "Does the tuberculosis work lend itself to a generalized plan of public health nursing?"

Health has been defined as "that quality of life which renders the individual fit to live most and serve best," and our objective as "that satisfactory adaptation of the individual to an environment which makes health possible." Tuberculosis as a part of that environment is a menace which cannot be ignored, and the tuberculosis aspect of public health nursing is a factor to be reckoned with.

### WHAT THE NURSE NEEDS TO KNOW

The nurse who wishes to give due emphasis to tuberculosis in her program must have some idea of the incidence of the disease in her community. When some one complacently states, "We have very little tuberculosis here" we may well ask, "How do you know?" By way of illustration comes the instance of one nurse who was sent into a county to organize tuberculosis clinics. The county was sparsely settled, the entire population about 15,000 and her headquarters a small town of three or four hundred persons. Twenty-one people were examined at the first tuberculosis clinic. Coöperating with this nurse were the Red Cross group, the Ladies' Aid Society and the business men. Perhaps most active of all was a banker who apparently recognized that there were physical needs in his clientele as well as financial for he had induced most of the twenty-one clinic patients to come in. Nineteen of that first group were diagnosed as tuberculous by the clinician! Of course, this was startling. The State Board of Health promoted this work with interesting results. Its workers found ninety cases. The presence of any appreciable

* Presented at the meeting of the New England Division of the American Nurses Association, Portland, Me., April 24, 1931.

amount of tuberculosis in that community had not been even suspected.

The nurse needs to know the age group most seriously concerned in the tuberculosis problem. We are told by authorities that in the age group fifteen to forty-five years, tuberculosis is "still captain of the hosts of death"; also among young women fifteen to twenty years of age the death rate has risen in recent years. Why this is so is worthy of study with a view to formulating definite objectives and a definite program with these groups clearly in mind.

What are the industrial hazards in the community related to tuberculosis? What is the urban death rate as compared with the rural? If there is a difference, why?

What of racial immunity? Is there really such a thing? What of racial immunity as compared to economic status? What has been found in studies of incidence based upon economic status? Is there less tuberculosis in the well-to-do, and if so, why might this be? It may be that we are called upon to serve in a community said to have unusually high per capita wealth. (The writer has worked in two such communities.) Our first question then would be as to distribution of wealth. Is the reputed wealth in the hands of a relatively few persons, and has this community as many poor as the average for its size? What about housing, crowding and unemployment?

What diagnostic facilities has the community? An authority in public health has said, "Never advise what cannot be carried out." If we advise physical examinations for people, places must exist where such examinations can be had. Are there adequate clinic facilities? Not infrequently the nurse must take an active part in the movement for establishing clinics.

What are the facilities for treatment? A specialist, nationally known, maintains that the tuberculosis cure is a "vaccination" which does not "take" in the home. What are the facilities for sanatorium care and for the hospitalization of emergency cases? Are they adequate? In one community last year, thirty per cent of the men and twenty-one per cent of the women on waiting lists died while waiting for sanatorium care. When the appropriations committee of that State legislature met, several public health nurses were present ready to talk of this tragic situation.

Another inseparable factor in the tuberculosis problem is economic aid. This need is especially evident in any disabling and long enduring disease. What are the laws of your locality relative to such aid? Some communities have a law which makes aid mandatory upon the community. So if hospitalization of a case is possible, the community in which the patient has a settlement must pay if he cannot. The value of knowledge of such laws is obvious.

### USEFUL STATISTICS

One index of the community health is its death rate. What, then, is the tuberculosis death rate? Last year's rate will tell us something, though not a great deal unless we know the rates of other communities and can compare. Comparing our situation with that of others gives us rank, but we also need to know trend. We study the past in order to predict, in a measure at least, the future. What has been our record over the fairly recent past and are we traveling in the right direction?

In the graph on page 379 a comparison of the tuberculosis death rate is shown for the country as a whole, for a state, and a community in the state, covering a period of five years. Here is revealed a steady decline in the rate for the United States and also for the given state but not as good a record for the community (population 170,000). This picture gave the public health nurse of that community much concern. Her next step in this connection was a further analysis of the situation. Such analyses should always be made with the coöperation of the local health officer who is the best informed medical advisor with respect to communicable disease work. Why

had the death rate in this community increased? In this particular case, the health officer called attention to the Negro problem. The figures revealed the fact that yearly tuberculosis death rates among Negroes were from three to five times higher than among white people over a period of eight years. This picture has aroused a deep, sympathetic interest in every worker on the Visiting Nurse Association staff. Why is the death rate so high in this group? Two-thirds of the Negroes who died last year came from Georgia. Obviously, the adjustment to their new environment was very difficult. A number of years ago the Negro immigrant came from the northern tier of southern states, but in more recent years the influx has been from the far South. This makes the adjustment a greater problem and we may conclude for the time at least, that it brings serious results to the Negro group.

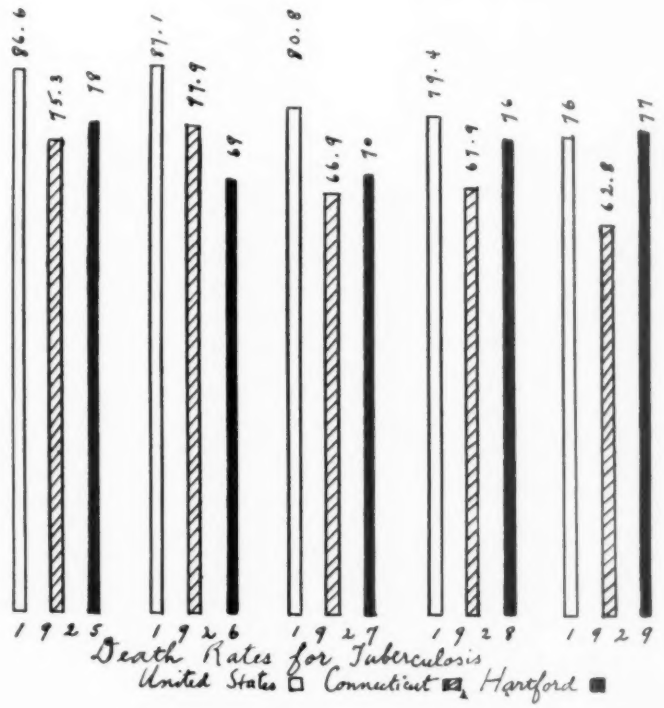
Another important factor in this study is the relation of the incidence of disease to the number of deaths. With good "tuberculosis work" there will be undoubtedly more living cases per death than have been recorded in the past. This is quite obvious.

In all of this activity the nurse should be familiar with the sanitary code. The requirements as to the initial reporting of cases and subsequent reporting should be part of her equipment.

### NOT THE ONLY WORKER

One of the most important things for the nurse to remember is that she, the public health nurse, is but one of a number of welfare agencies in the community. She has many co-workers outside of her own immediate group. It therefore behooves her to devise a successful plan, or technique, of coöperation with those agencies.

The nurse must sell her job to the physician. "No visit" cases are those which the doctor does not wish to have the nurse visit. While there are a few



such cases in the community and while there will always be some, no one is more prompt to use the nursing service than the doctor when he sees the value of it. One doctor said upon being asked if he wished the nurse to call upon his patient—"No. But if he becomes uncontrollable, I will set you on him." This doctor no doubt saw in the nurse a person with some police power but certainly with no educational function. When the nurse makes herself felt as an educational asset to the doctor, she will be incorporated in his program. In 1928, one community had not less than seventy-six "no visit" cases; in 1929, twenty-four; and in 1930, fifteen.

Know the Appraisal Form of the American Public Health Association—its background, how it originated, and its proved value. Is it being used in rating the health performance in your community? In any case the nurse should know its minimum standards which are:

Case finding
- 2 new cases per annual average number of deaths
- 5 known living cases per annual average number of deaths.

Clinic service
- 15 visits to the clinic per death
- 3 visits per patient registered
- 25 per cent of diagnosed cases should be in incipient stage only
- 3 contacts per each new positive case registered at the clinic.

Field nursing
- 50 visits per death
- 8 visits per diagnosed case registered with nursing service
- 10 visits per death to postsanatorium cases.

Hospital care
- 250 patient days per death
- 25 per cent of total admissions incipient cases
- 10 per cent of total admissions children under twelve.

Knowing how her community ranks in its health activities on an accepted basis such as the above is important to the nurse. It adds a feeling of stability; insecurity vanishes, for she knows where she stands in relation to the work of other communities and where her best efforts are needed.

And, lastly, the nurse must know the manual techniques essential in the communicable disease program, for, as has been stated, tuberculosis is one of the communicable diseases. While safeguarding others, we must still guard against giving the patient too great a sense of isolation, we must remember his cure is a long one, and while certain precautions are essential, we must not over-emphasize them.

### THE NURSE'S OWN ATTITUDE

The approach to tuberculosis must be a thoughtful one. Some information regarding the disease is fundamental. There are two small booklets, publications of the National Tuberculosis Association, the contents of which every public health nurse should know since tuberculosis cannot be ruled out of any environment. The titles of these booklets are "Diagnostic Standard, Tuberculosis of the Lungs and Tracheobronchial Lymph Nodes"; and "Childhood Type of Tuberculosis—Diagnostic Aids." *

Tuberculosis is both communicable and chronic. It is the combination of these two factors which makes the disease so difficult to face. It is no wonder patients fear it and uninformed nurses view it with more or less apprehension and prefer other phases of public health work. Tuberculosis suffers by comparison. In infant health work, for instance, there is ever the thought of a responsive, desirable baby; in child hygiene work the lovable, preschool youngster—often a behavior problem, but attractive nevertheless; in prenatal work the anticipation of a healthy baby; the school group may tire us with their zeal and almost frighten us sometimes with their insistence along certain lines yet they are full of promise and the zest of life. But in "tuberculosis work" there is still the same old picture of the coughing, spitting, emaciated and often repulsive individual. To the informed,

* May be secured from the National Tuberculosis Association, 450 Seventh Avenue, New York, N. Y.

this is not a completely discouraging picture, nor does it represent the true situation. We do have a number of such seriously ill tuberculous patients, but far more often we are concerned with the patient who shows practically no obvious evidence of the disease. In one visiting nurse association where the students have regular excursions to a nearby sanatorium, members of this new, inexperienced group invariably remark that the patients are so young, so good looking!

Tuberculosis is a disease of youth and this is most significant. At this time the young person is looking ahead toward the many things he is going to do. He is going to be president of the United States—he is going to have a good job—or, perhaps, he is going to earn money with which to buy things for mother. There is always the eager forward look. On the other hand, the peak of the death toll in heart disease comes in the age group, seventy to seventy-four. At that age we look back at our past. Psychologically, there is considerable difference in our approach to these two "chronic" diseases, aside from the disabling factor in either.

We come into this world with a certain equipment, certain fundamental needs which are as deepseated as the urge to eat when we are hungry. One of these needs is for a sense of security. Where is the sense of security in this young group on the threshold of their adulthood when faced with the actuality of tuberculosis? How does this young person, just diagnosed, feel about it? Is not this the nurse's very first concern? For who can stop to consider the care of sputum, or boiling dishes when his world has suddenly slipped from under him? A noted psychiatrist has said, "We share with our contacts, our poise, our serenity." Here the nurse has a definite responsibility. We must approach the problem with thought, with concern, and with consideration.

What is our general procedure then? With considerable information as a background, we should have developed a rather deep sensitivity to the problem. Very briefly, our immediate aims are:

To educate and care for the tuberculous member of the family by means of
- Proper home care.
- Sanatorium care.
- Stimulating attitudes favorable to recovery.
- Continuous health supervision.

To educate and protect the other members of the household by means of
- Examination of contacts.
- Continuous health supervision.

To be constantly on the alert for the detection of symptoms which point toward tuberculosis through
- Work with malnourished children.
- Supervision after any acute illness.
- Contact in the home for other services.
- Coöperation with all agencies in the community which have to do with family welfare.
- Making proper use of all community resources for the elevation of health standards.

In the case of children found to be infected with tuberculosis the following is a good workable routine:

- Break the contact.
- Relieve all possible strain.
- Build up the health.
- Carry out this program without harming the child emotionally.

Health work should not be directed at the child in such a way as to make him conscious of it for that might make him self-centered. Let us guard against possible emotional problems through careful analysis of all our plans.

It is said that a man once asked Socrates, "How can I reach Olympus?" to which Socrates answered, "By walking in that direction." Have we not an Olympus and are we walking in that direction?

# What Vitamins Are*

By LAURA COMSTOCK
Nutrition Adviser, Eastman Kodak Company, Rochester, N. Y.

"YOU are always talking about the value of vitamins. I wish you would make me a chart showing what they are good for and where they are found. I get them terribly confused," one of my friends said the other day.

Well, I thought, if she is having trouble keeping the vitamins straight, perhaps other folks are, too. Here is the outline I made for her:

### VITAMIN A

*What Vitamin A Does:*

Promotes growth.
Helps to regulate the body.
Aids appetite and digestion.
Helps to prevent colds and infections of eyes, ears, sinuses, bronchial tubes, and lungs.
Promotes better health and longer life.

*What Happens When There Is Not Enough Vitamin A:*

Stunted growth and development.
Loss of appetite.
Disturbed digestion.
Lowered resistance; colds and disease of eyes, ears, sinuses, throat, lungs, and kidneys may result.
Poor health and probably shorter life.

*What Foods are Rich in Vitamin A:*

Whole milk, butter, cream, cheese, egg yolks, *green*, leafy vegetables (spinach, the best), yellow vegetables, tomatoes, liver, cod-liver oil, fresh or dried apricots, yellow peaches, prunes.

Vitamin A can be stored in the body. We need a good reserve amount to keep us well and vigorous.

### VITAMIN B

*What Vitamin B Does:*

Increases appetite.
Promotes digestion.
Helps keep the intestinal tract healthy.
Promotes growth.
Protects body from nerve disease.

*What Happens When There Is Not Enough Vitamin B:*

Loss of appetite.
Loss in weight.
Stunted growth.
Lack of vigor.
Indigestion.
Constipation.
Nervousness.
Muscles of intestinal tract weakened.

*What Foods Are Rich in Vitamin B:*


Whole grain cereals, beans (all but fresh Lima), vegetables (spinach, cabbage, tomato, richest), milk, cheese, egg yolks, nuts, oranges, lemons, grapefruit, liver, yeast.

Vitamin B is not stored in the body. To keep well we should eat each day foods which contain it. Adding soda during cooking of vegetables rapidly destroys it. Where vegetables are cooked in water some of the vitamin is dissolved in it—use this water when possible.

### VITAMIN C

*What Vitamin C Does:*

Promotes good health.
Promotes vigor.

* Reprinted from *The Kodak Magazine*, November, 1930, through the courtesy of the Eastman Kodak Co.

Aids in keeping teeth in good condition.
Prevents scurvy.

*What Happens When There Is Not Enough Vitamin C:*

Lack of appetite.
Loss in weight.
Loss of energy.
Hinders growth.
Fleeting pains.
Teeth defects (decay and pyorrhea).
Irritability.
Sallow, muddy complexion.
Lowered resistance.
Scurvy results when there is very little vitamin C in the diet.

*What Foods Are Rich in Vitamin C:*

Canned or raw tomatoes, oranges, pineapple, strawberries, grapefruit, raw cabbage, and carrots are the richest in vitamin C.
Other raw fruits like bananas and apples and green, leafy vegetables are good sources.

Very little Vitamin C is stored in the body. We need to have a fresh supply each day. It is easily destroyed in cooking and canning except when there is acid present.

**VITAMIN D**

*What Vitamin D Does:*

Prevents rickets.
Cures rickets.
Helps to build good teeth.
Helps to preserve good teeth.
Necessary to form good bones.
Helps the body use calcium (lime) and phosphorus as it should.

*What Happens When There Is Not Enough Vitamin D:*

Rickets.
Poor teeth.
Poor bones.
Body can not use calcium (lime) and phosphorus as it should.

*What Foods Are Rich in Vitamin D:*

Cod-liver oil, other fish oils, egg yolks; a little in butter fat, cabbage, and fresh spinach.

Vitamin D can be stored in the body for a short time only. As so few foods contain it, we are apt not to have enough to keep well.

Scientists have found that the ultraviolet rays of the sun can make Vitamin D. As a result "sun baths" and "light" treatments may help out the shortage in foods.

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## LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR AUGUST, 1931

# County Drought Relief

## *A Public Health Nurse's Problem*

By ANNE L. WHARTON

Madison County Chapter, American Red Cross, Madison, Va.

THIS winter it was my privilege, as an itinerant public health nurse, to be able to work with the Red Cross Drought Relief Committees in two of our stricken counties, both in the mountain section of Virginia, but each handling the situation in a different way.

The first county in which I worked was launching its first year of public health nursing service under a newly formed Red Cross Chapter. The service had hardly started in the fall, before we knew we were confronted with a big relief problem. Calls for aid began to come in, slowly at first, but increasing in number daily.

### TO MEET THE EMERGENCY

An Emergency Clothes Committee was organized. Children were coming to school thinly clad, clothing and shoes worn out—scant protection for the bitter cold of the mountains. The chairman of this Clothes Committee solicited gifts of clothing; ministers were requested to speak of the need to their congregations; notices were put in the county papers asking for donations and all teachers were requested to send in lists of people who needed or would need help during the winter.

Though at first a great deal of the work both of investigation and distribution fell to the nurse, gradually the Committee, eager at all times to help, accepted more and more of the responsibility. Before long relief cases were referred to them, the Committee both securing and distributing the supplies as needed. The Junior Red Cross was also most helpful in supplying clothing to specially needy cases among the children, completely equipping a little blind boy who was sent to the School for the Blind.

Where provisions were needed, these families were referred to the churches or other local organizations in that community or to the County Board of Supervisors. When possible, work on the county roads was given to heads of families applying for help. However, it was not long before all local resources were exhausted and the Drought Relief Committee was formally organized and all cases turned over to it. All members of the Committee were most interested in the work and we had splendid attendance at all meetings of both the regular Red Cross and the Drought Relief Committees, but as the work was so new to the county, we all had much to learn.

Throughout this rural county, composed of small communities widely separated, district sub-committees were formed, reporting at stated intervals to the Central Committee. As the nurse found cases of need in her calls or work in the schools, these were referred to the district investigator. In turn the Committee reported to the nurse all cases of sickness, or those presenting health problems, physical or mental, as well as cases where the welfare of children was especially involved. It was no time to try to differentiate between social service and public health nursing problems, for there was no one else to help with either, save the public health nurse, and the need was acute.

### MORE THAN DROUGHT RELIEF

One case was especially interesting. A mother desperately ill with puerperal septicemia, and her ten-day-old baby, also very ill, had to be taken to the hospital for medical care if the life of either was to be saved. The father drank and so could hold no steady job. The garden had failed during the past

summer and the home was in a most dilapidated condition. There were ten children, besides the new baby, the oldest being a boy of 17 years. One boy was nearly blind, another had Hodgkins disease and needed hospital care; another child, the only girl, was very backward and several presented rather serious behavior problems. The day after the mother left, the father "went on a spree," leaving the children alone in the home.

After consultation, it was decided to place the children in foster homes. It was no small task to find homes for eight small children but in less than a week all were comfortably settled, the older ones attending school for the first time that year. The sick child was taken to the hospital, the backward child given a thorough physical and mental examination and the blind boy sent to the School for the Blind. Through the aid of the Judge of the Juvenile Court, the father was put in jail, later being released on promise of keeping sober and going to work. It was not easy for him to find work, but he persevered and has been working steadily for several months. Helped by friendly visits and encouragement, the man has kept his promise and has been most coöperative in all our plans for the family. The wife and baby recovered, though for days the mother was not expected to live, and are now back at home. The children are gradually being returned to their home as their mother regains her strength and is able to care for them. The family life has been saved. The story of this case spread throughout the county for it had long been a problem and the man was only too well known. Somewhat to our dismay we learned that some of the wives used his experience as a mighty weapon whenever the husbands were inclined to loaf on the job!

#### UNTIRING COMMITTEE WORK

The second county where I served had had an itinerant public health nursing service for the past four years and was therefore well organized. By the time I came into the county in February, the Red Cross Drought Relief Committee was hard at work. Here there was a Central Committee handling all the cases with the aid of investigators scattered throughout the county. I have never seen any Committee work more faithfully or untiringly, spending daily three hours, and generally more, in work at the Chapter office—all volunteer workers. A well established Clothes Committee took charge of all requests for garments. The names of all cases of sickness as reported by the investigators were turned over to the nurse. Through this means we were put in contact with many needing medical care.

Because of the great need, due to the isolation of some of our mountain sections, classes in Home Hygiene and Care of the Sick for mothers are being started in two of our most isolated communities, and lessons on simple home nursing, and on sanitation, nutrition and prenatal and infant care are being given. Mothers are also encouraged to bring their babies to the nurse to be weighed and measured and to consult with her.

The Drought Relief Committee is now finishing up its splendid work of many months past, most of the families helped having again become self-supporting. Interested committees have been formed and have functioned most efficiently and the work done and the information gained will be of inestimable value to our nursing service as well as to the Chapter. Health clubs, which are the outgrowth of the home hygiene classes held in various sections of the county, have been a great help to the nursing service and also to the Drought Committee by reporting cases of need. These clubs are establishing loan closets furnished with bed linen, and supplies for needy sick people in their neighborhood, and are making maternity kits as their part toward furthering our maternity and infancy program in which we, with other counties throughout our whole country, are so vitally interested.

# Home Nursing and Newspapers

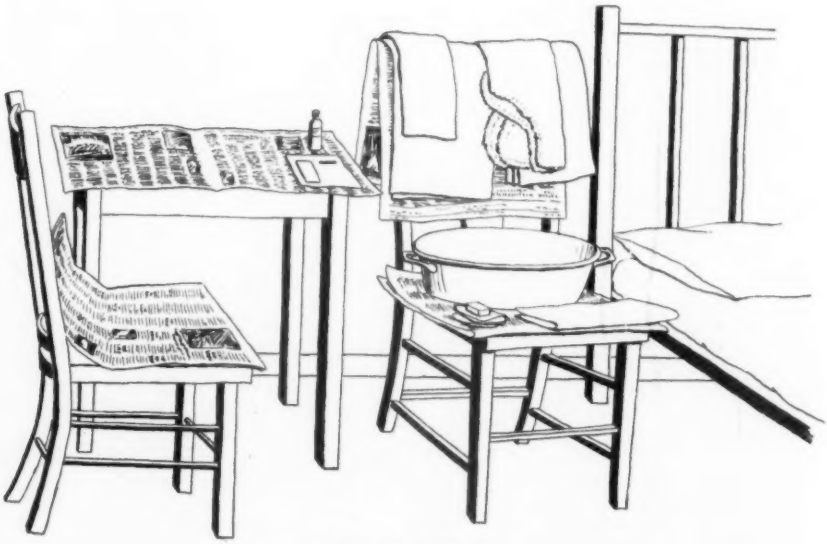
By MARION DICK KIRKCALDY

Supervisor, Student Practice Center, Visiting Nurse Association of Chicago

"HAVE you any newspapers?" is the question which invariably follows the salutation of every public health nurse giving bedside care—at least it is asked in the homes of all new patients; in our old and well-trained families we anticipate that a supply of newspapers will be in readiness for us. From the simple lesson of providing newspapers for the nurse, the families soon realize that some further preparation for her visit is necessary. They like to feel, too, that they are helping to care for their own.

Greetings over, the nurse must not only dispose of her wraps and field bag, but also determine what part of the house will serve best as a work-room. Without a doubt the kitchen will be best, for it is usually the only work-space in the house and has running water, a stove, kitchen utensils which may be needed, and a table. Few homes, whether tenement or bungalow, have bath-rooms large enough or warm enough to serve as nursing work-rooms.

Selecting a chair, the nurse covers the back and seat with newspapers. On these she puts her bag, hat and coat. The coat should be neatly folded with the inner surfaces together. Having a definite place for wraps and bag not only teaches a good routine but eliminates awkwardness, especially on the part of the new nurse.



*General bedside care*

Clean hands are almost the beginning of wisdom in any nurse, but in district homes they are the first step in any demonstration calculated to impress the family; therefore, the first thing the nurse does is to wash her hands thoroughly. A newspaper is placed on the kitchen sink. On one end is placed the soap, brush, nail stick, and towels, and at the other end, the paper towels used in drying her hands.

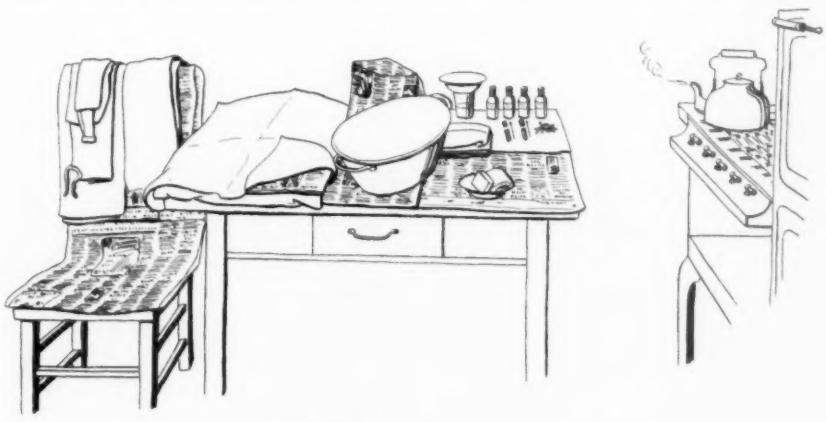
To make the sick comfortable should be the uppermost thought in our minds. The way to do this in a district home is not as hard as it seems at first to the new nurse. Two chairs and a small table are covered with newspapers. Equipment from the nurse's bag is placed on the table. One chair is used for clean linen and toilet articles and on the other one are placed the soiled clothes. (See illustration on preceding page.)

For the baby born at home, methods must be worked out to insure care as nearly adequate as that offered in the hospital. Again, for the time being, the kitchen table is one of the most important articles in the house and makes a good substitute for the hospital nursery table. Cover it with newspapers. On this place a flat pillow for the baby. This pillow is protected with several thicknesses of newspapers covered with a soft diaper or towel. Be sure that neither pillow nor baby gets too near the edge of the table. Never leave the baby alone on the table—even a very young baby can make a sudden movement sufficient to roll him off the pillow and table. A bag made of newspaper may be used for soiled cord dressings and cotton pledgets which have been used for eyes, nose and thermometer.

A chair is placed at the side of the table. Newspapers are arranged on seat and back. Clean clothes are set in order on the back and the soiled ones collected on the seat.

In our maternity work we teach the family to make this preparation. School children love to do this—that is, if the new sister or brother arrives during the school vacation. At other times, we find that husbands, sisters-in-law, and even grandmothers make apt pupils.

For the care of the mother, a chair placed at the bedside is covered with newspapers. Clean linen is arranged on the back and on the seat are placed the materials required for the perineal dressing. The same newspaper bag used in the care of the baby is again used to collect soiled dressings. The mattress can be protected by an improvised newspaper sheet made of several papers tacked together. Pads used as substitutes for a draw sheet are made with newspapers and covered with old, clean linen. These pads are particularly helpful when the supply of clean linen is limited. The same idea on a



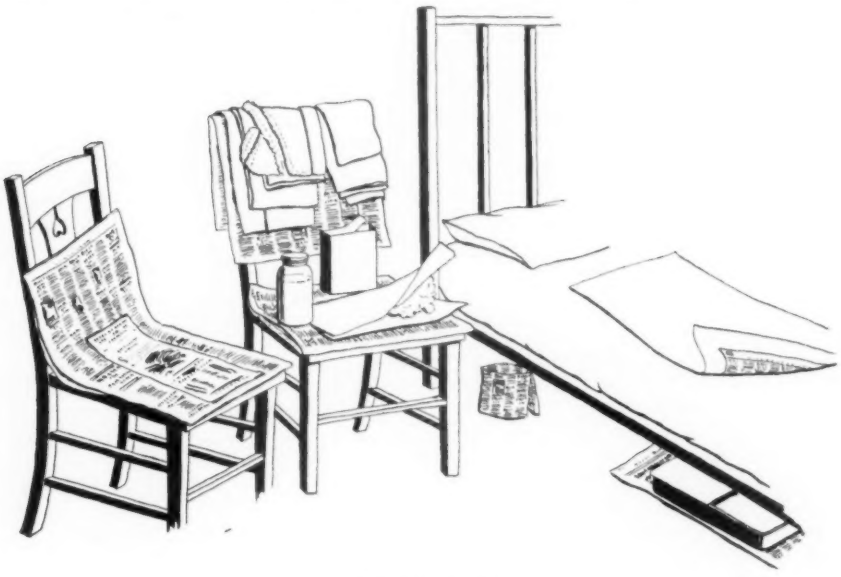
*Care of the newborn*

smaller scale can be used for the baby's bed.

Placing a bedpan between folds of newspapers emphasizes the point which is necessary in some homes, that this utensil must be kept clean. In some homes it is impossible to heat a bedpan, but it can be made less uncomfortable by covering the end with newspapers.

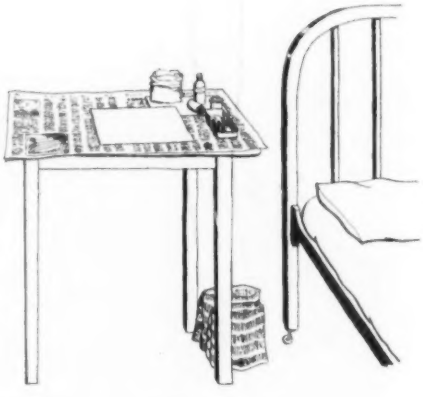
Soiled linen is collected on a newspaper placed on another chair. Many bedrooms are too small to allow an extra chair but one can be placed just outside the bedroom door. If chairs are scarce, ingenuity will solve the problem: boxes, even barrel-tops, make fair substitutes for chairs or tables.

Surgical dressings can be made in the bedroom on a table or on any other article of furniture which will serve the purpose. Protect the table with newspapers. Set out articles for the dressing. Make two newspaper bags: one for soiled dressings that are to be burned and the other for the binder or bandages which require washing. Sometimes it is impossible to make dressings in a bedroom. The kitchen table may be used for the preparation and then dressings, instruments and other equipment may be placed on a chair at the bedside. If the patient is up and about, the kitchen can be utilized as a dressing room by placing a chair for the patient at the side of the kitchen table. If a kitchen is warm and reasonably clean, it must serve for all sorts of treatments.



*Maternity care*

In the care of pneumonia, newspapers are again useful. The dresser or a table covered with newspapers makes a convenient place on which to keep the articles necessary for the patient's care. The recognized procedure



*Surgical dressings*

for the care of a gown is to hang it near the door inside the patient's room. In visiting nursing this method is not always practical because of the great variety of homes and other difficulties encountered. The gown should be folded with the inner surfaces together. The clean side will then be next the nurse's dress always. The folded gown should be placed in a clean newspaper and left in the patient's room.

Patients suffering from pneumonia, tuberculosis or severe colds, should be taught to expectorate into folded squares of toilet paper. These are

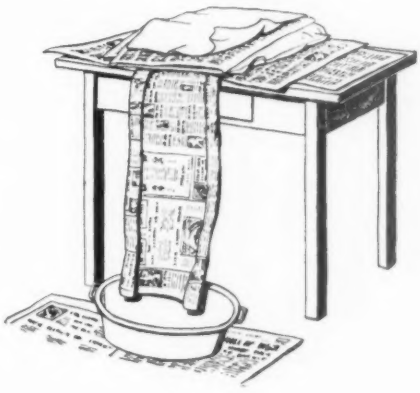
*Pneumonia care*

dropped into a bag made of newspaper, which is pinned to the side of the bed within easy reach of the hand. The family should be taught to burn the bag frequently; also how to make and replace it.

If hot bricks are used when giving packs, the patient and the bedding can be protected by wrapping the bricks in several layers of newspapers.

A "Kelly Pad" is made by rolling both edges of several newspapers folded together. This device is serviceable when giving enemata to babies and small children.

Miss Nightingale in her excellent book, "Notes on Nursing," reminds us that it is the duty of every nurse "to try to vary the thoughts of the sick." Sometimes special funds are available to obtain extra comforts for the lonely and for shut-ins. The final illustration



suggests a method of keeping such patients in touch with outside interests by providing them with a daily morning or evening newspaper.

These are only some of the ways in which public health nurses caring for

the sick in their own homes may use old, clean newspapers. Newspapers have one other important function—Their constant use tends to develop methodical procedure and thereby saves both time and energy.

# Thirty Miles from a Post Office

By ELISE R. PIPPEREIT, R.N.
GANADO, ARIZONA

THE Fanny G. Childs Community House, which was opened last May, is the newest out-station of Ganado Indian Mission, Arizona. It is thirty-three miles from Ganado, which is our post office. We are ninety miles from a town, when the road over the mountain can be used. In winter one has to follow a road that makes the distance one hundred and twenty miles, since snow on the mountain prevents use of the former.

*The Community House. It has a dispensary, bedrooms and bath for the nurse and interpreter, living room and kitchen. There is also a bathroom for the use of the community!*

Our first adventure came when we had been here but two days. A man arrived, asking us to visit a sick baby. He had come on horseback over the mountain, and it was not far that way, but the way by car was farther. (I have since learned that the Indians seem to have no sense of distance.) We had gone with him only the distance of perhaps two blocks, when we turned sharply and found ourselves on a steep, narrow, winding road: and I an inexperienced driver! Every little while it was necessary to shift gears because of ruts across the road. We had left the community house about four o'clock. After repeated questions to our guide, as to how much farther we had to go, he finally said that if I would drive faster we could be there at sundown! At 7:30, as the sun was setting, we found ourselves hopelessly stuck in sand, in an arroyo. A man who spoke some English tried to help us, but did not succeed. He told us of a trading post half a mile away—it was two or three miles—but since he would not offer to tell the trader of our plight, I started to walk toward the distant light. After going through an arroyo I was unable to find the road, and by this time the moon had gone down. At last I saw the lights of a car approaching and thought that after all the English-speaking acquaintance must have gone for help to the trader. Alas! my hopes, which had risen, sank; for the car turned; and, being some distance away, my calling could not be heard! I could see the lights of our car, and could see that the other car went there, stopped, and then went away. Knowing that my interpreter, who had stayed with our car, would tell the trader that I had gone to find him, and fearing I might miss him again, I ran as fast as I could, calling as I ran. Suddenly I went down, down, into a deep arroyo—(I was told later that it was 14 feet deep). It was so steep that in trying to get out I slipped back again and again, but I called constantly and finally, to my great relief, as I reached the top, I saw a flashlight coming toward me. It was the trader. No one will ever know how glad I was to be greeted by a friend—stranger though he was to me.

With the help of several men, our car was soon pulled out of the sand, and we were taken to the trader's home and given supper. It was 10:30 in the evening when we arrived there. We had gone 28 miles in 6½ hours! On returning to our car, I found that our guide had deserted. We had only a mental picture of him, as a Navajo will

almost never tell his name if he can avoid it.

The next morning we were shown a place where we could cross the arroyo in which we had been stuck, and we started home. We were about four or five miles from home when we saw a car coming toward us. In so isolated a place, where a car is seldom seen, one wonders! Finally we recognized neighbors who had seen us start the day before, and knowing the man who had come for us lived thirty-five miles away, and also knowing the condition of the roads, had feared for us. They had gone all that distance in search of us, taking food in case we had had none. Again we were thankful for our new friends.

*Four generations were living in this summer hogan. Community worker and interpreter at left of picture*

In September we were called to see a pretty little girl of five, who was suffering from an intestinal disorder. She was sitting on the dirt floor of her home. (We usually find sick people sitting up.) Repeated efforts to persuade her mother to allow us to take her to the 75-bed hospital at Ganado were in vain. It was during the season when green corn is extensively eaten. The mother was told the importance of the proper diet and soup and milk were taken or sent a number of times. After a time the mother said that the soup made the child worse; the medicine did no good and she continued to feed corn, coffee, and Navajo bread, with raw green squash for variety. Bathing, also, was not good for the child. (For baths and enemas I take hot water in thermos bottles.) A medicine man was then called.

We insisted that the child should lie down, but we found only the upper part of her body on a sheepskin—the rest was on the bare ground since the mother did not want the sheepskin soiled. Sacks were sewed together, and the mother told to put corn husks into them; and an old comforter was given to put over this. This also was not done. The mother steadily refused all aid, even for the child's comfort.

Months passed. Each time we saw the child she was weaker and thinner. The last of January, the mother came to tell me that the child was dying, and asked if I would prepare her for burial. I got out the car and took the mother with me. Pointing with her lips, Navajo fashion, she showed me which way to go after we got out of the car. There, at the foot of a hill was a cir-

cular shelter made of branches of juniper and piñon trees, about six feet high at the highest place, and sloping down to about two feet at the entrance. Near the entrance was a small fire, and beyond this, wrapped in a comforter, which had been new when we gave it to her early in her illness, lay the little girl, cold as she could be. The Navajos have a great fear of the dead, and a hogan in which any one has died, must not be used again.

What did those people want, but to have me take that dying child to the hospital! When, after much talking, and many arguments, they saw that I would not do that, they asked if I would take her after she died. I finally offered to spend the night with her.

Stones were gathered, heated in the fire, wrapped, and placed around the child, in an attempt to get her warm. Toward morning the child died. When the usual preparations for burial had been made and the body put into the rude coffin I had carried over in the afternoon, the mother wished the child's face to be painted. Since I pleaded ignorance, the matter was dropped. When the elder daughter left the shelter, the mother took some brush and patted the earth to obliterate the footprints, so evil spirits could not follow. One thing more was insistently demanded of me—that I dig the grave!

The mothers know nothing of the care of babies, and it will take a long time to educate them. Our ways seem so absolutely wrong to them. They appear to have a rule that a baby must not cry. When he cries, there is only one thing to do, regardless of the cause, and that is to feed him.

Trachoma and tuberculosis are rife. With as much sunshine as there is here, the latter should not be a menace, but when one sees how the children are fed and cared for, the reason is easily understood. We gave clothing to many children during January and February. None had underwear, few had stockings, and a number had no wrap of any kind. The babies are usually dressed in one garment, regardless of the weather. When a mother asks for

*Babies are a year old the[y] [are] "cradles" a good part of the time. They are laced in so tightly they cannot move*

cough medicine for her baby I try to find out how the child is clothed. One baby which was in a "cradle" had on an outing flannel gown which we had given it. In order to keep it clean, the mother had doubled the gown over the baby's chest. A flour sack and bath towel were used to cover the baby. A folded diaper was under its head. Children five or six years of age are sent out alone to herd sheep in winter. They have no lunch at noon. Sometimes a three year old child will be sent out with an older child.

Besides health education, which is so very much needed, the Navajos need liberation from their religion of fear and superstition.

From Miss Katherine Tasker who is working in the hospital of the Episcopal Mission of the Navajo Reservation, Ganado, Arizona, comes this additional note and picture relating to the work among the Indians.

I have held two conferences with a total attendance of twenty-eight children and twenty-four mothers. The interest shown by the Navajo mothers is remarkable, for

unlike even foreign mothers of our cities, they have had absolutely no child welfare teaching or training along that line of thought through the generations. Their babies either live or die with no thought as to cause or effect.

The follow-up visits into the native hogans reveal some dire needs which are hard to believe exist in our highly civilized United States. The people live in log and mud huts, some scarcely six feet high. They sleep on sheep skins and cook around a charcoal fire in the center of the hogan. The babies play about on the ground either naked or very scantily dressed while the mothers sit at a loom weaving or carding wool. When the children are four or five [illegible] age they are sent out on the range herding sheep. [illegible] live chiefly on mutton, ba[illegible] and Navajo bread—a kind of biscuit dough [illegible] at.

[illegible] education and methods of liv[illegible] are gradually making an imprint on their h[illegible]s and usually where some member of the family has been to school one sees an upward trend toward cleanliness. Some have even built stone or log cabins where there are a stove, rude beds and tables and invariably an ornate clock which may or may not keep time. Time is of very little consequence to these people.

Any teaching which I may do must be primitive, measured by standards of public health nursing as we know it, but I believe a few years will see real changes and results in healthier babies.

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## A STORK AND A BABY

Over 5,500 entries from professionals and amateurs throughout the world were included in this year's exhibition of soap sculpture recently held in New York City, and now continued at museums and art galleries throughout the country. The "Stork and Baby" was carved from a cake of white soap by Edward Epperson, a sixteen year old boy of Cincinnati, Ohio, and is one of the prizewinning sculptures in the senior amateur group.

When one sees the simple tools with which this carving is done, and meets with a group of men, women and children who are fascinated with this "sculping", one longs to make a hobby of this activity as well as to adapt it to the needs of chronic and convalescent patients. In this connection it is interesting to note that a scholarship prize for a year's study in art school was won by a lad from the New York Institution for the Deaf. Also, a number of excellent pieces were on view from Longview Hospital for the Mentally Ill, at Cincinnati, Ohio. High schools were widely represented. Here is a suggestion for the rural teacher and nurse who may have a bit of artistic skill, and for the bedside nurse who is at her wits' end how to keep a cardiac or infantile paralysis case quietly occupied in bed.

The address of the School for Soap Sculpture is 80 East 11th Street, New York City.

# POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

## PRESCHOOL CLINIC PROCEDURE IN PUBLIC HEALTH NURSING ORGANIZATIONS

Following a number of inquiries for such material, the N.O.P.H.N. recently requested information on preschool clinic procedure from public health nursing organizations in various parts of the country. Details and informal comment were desired on the following points:

Clinic Rooms: Type of building; light; heat; number of rooms.
Clinic Furnishings and Arrangement of Space: Convenient and attractive furniture; posters; toys; clinic devices; floor plan.
Doctor's Table: In detail.
Clinic Procedure for Child: Description.
Personnel: Including doctors, nurses, dental hygienists and lay workers, with duties.
Routine: Including admitting; use of appointment system or other attendance systems; undressing and dressing; facilities for weighing and measuring, and method; inspection and (or) examination; conference with parent; amount of fee if any; follow-up in home; return to clinic how often.
Frequency of clinics and number of stations; average attendance; record form; successful features; problems and difficulties; plans for future development.

The organizations which responded with material full enough to be used represent varying geographical blocs in which climate and type of population might affect clinic procedure considerably. Contrary to the age limit we originally had in mind, these organizations do not all carry infant and preschool clinics as separate projects. It was decided, therefore, with material of so great interest, to abandon the age distinction in the presentation of this information.

This material, so arranged as to give the procedure of seven organizations in juxtaposition, will appear in Policies and Problems Department until the above outline is covered. The participating organizations will be designated hereafter only by the cities they represent:

1. Brockton (Mass.) Visiting Nurse Association
2. Charleston (S. C.) Public Health Nursing Service of the Department of Health
3. Hartford (Conn.) Visiting Nurse Association
4. Houston (Texas) Public Health Nursing Department
5. Minneapolis (Minn.) Infant Welfare Society
6. San Francisco (Calif.) Department of Health, Bureau of Child Welfare
7. Syracuse (N. Y.) Bureau of Nursing, Department of Health

The reader is asked to keep in mind the fact that these pages are like an "experience meeting"—where ideas, ways and means, and experiments are reported. We are not trying to offer ideal methods or outline standards. Comments on any of these procedures will be welcomed.

### I. CLINIC ROOMS

*Brockton Visiting Nurse Association:* Young Men's Hebrew Association headquarters—two large steamheated rooms with toilet facilities. Southern exposure, well lighted.

*Charleston, S. C.:* Held at City-County Health Center in rooms especially arranged for the purpose. Large three-story brick building, originally a residence. All rooms large and airy. Central heating. Electric fans and indirect lighting in all rooms. Two rooms used for clinic—a large one for the mothers' waiting room with four windows and three doors, opening on wide piazza; small room with three windows and also opening on piazza, for doctor's room.

Clinic for colored children held in quarters rented from colored Y.W.C.A

*Hartford:* Large room with small room adjoining for doctor's office, located in school building, preferably with southwestern exposure. As easily accessible as possible to street for sake of mothers carrying babies, and toddlers. Not near classroom as crying will be disturbing. Only drawback is lack of heat in stations when there is no school.

*Houston:* Three examples given as follows: (1) West End Health Center in frame building, using gas heat in winter, located about two miles from nearest clinic. Rent $10 a month. (2) Avenue K Health Center (Mexican) frame building, other items as above. Rent $13. (3) Bethlehem Health Center (colored). Space in Club Room of Settlement House. No rent.

*Minneapolis:* Seven of nine clinic stations are in settlement houses; one is in the rooms of the pediatric department at the University of Minnesota; one is in second floor of business block where other welfare agencies have offices. At least two rooms—one large waiting room, one smaller room for doctor's examination. Running water. Type of rooms depends on space available in the settlement house. In one station the auditorium is the waiting room and the stage is doctors' examining room with only a closet for the nurse to store her supplies. In others the doctors' room is the nurses' office and is used for no other purpose than for Infant Welfare Society. Each station has its own telephone. No rent is paid for any space. With the exception of the University all the buildings receive their support from the Community Fund as does the Infant Welfare Society.

*San Francisco:* Conducted in the following types of buildings: Neighborhood clubs, Central Health Office, Department store. All on first or second floors. Varied ways of heating as electricity, electricity and wood, wood and coal, steam, gas. Number of rooms varies from one to four: the clinic held at the department store has four rooms; at each of the two health centers, three rooms.

*Syracuse, N. Y.:* Public school buildings; two in health centers and one in Negro Settlement House.

## II. CLINIC FURNISHINGS AND ARRANGEMENT OF SPACE

*Brockton:* Reception Room: Comfortable chairs and individual baskets for children's clothing. In center a table with health pamphlets. At one side of room long table with scales at one end and instruments and equipment for giving toxin-antitoxin and vaccination at the other. Health posters displayed and toys provided for children while waiting. Examining Room: Equipped with washing facilities, a gas stove, table for examination, desk for doctor, stools for children and chairs for parents.

*Charleston:* Stationary hand basin in each room. In waiting room comfortable opera chairs, and a large cushioned circular seat; scales, with metal scoop, for weighing and measuring children; a table used for demonstration of formula routines. In one corner facing a north window is a dental chair and apparatus used only for children at our dental clinics; a white enamel instrument cabinet with an electric sterilizer; a wall cabinet. Around the walls are posters, obtained from the National Child Welfare Association, depicting child care and development, prenatal care, diets, and other subjects. These are changed from time to time. On a bulletin board, changed every few weeks, a special poster or other object lesson is put, emphasizing some particular point. Unfortunately we have no toys for amusing toddlers. Planning to have a sand pile built in yard.

Other equipment in the doctor's room includes a white enamel instrument cabinet with attached electric sterilizer; white enamel trash-can with automatic cover, table holding record files, table holding microscope (used by the Epidemiological Dept. of Health Center); a wall cabinet; posters of height-weight-age tables.

*Hartford:* Individual tables covered with bright oil-cloth on which to undress infants, a separate sheet of white paper used for each child. The nurses sometimes use layers of newspapers for padding under the oilcloth. The table legs, chairs, scales, etc., are painted to carry out the color scheme of the room. Attractive curtains at windows, and colorful posters on walls illustrate particular points nurse wants to put across to mothers. We find that magazine pictures cut out and mounted, one point per poster, worded simply and plainly printed, work out best. These may be changed from time to time to attract renewed attention to these points.

One corner of the large room is set aside for preschools. A low table with small chairs borrowed from kindergarten provides a place for them to sit and play with the picture books and toys furnished. Pictures on the wall in preschool corner at the children's level, representing subjects interesting to them. The preschool scales are just between the preschool corner and the rest of room.

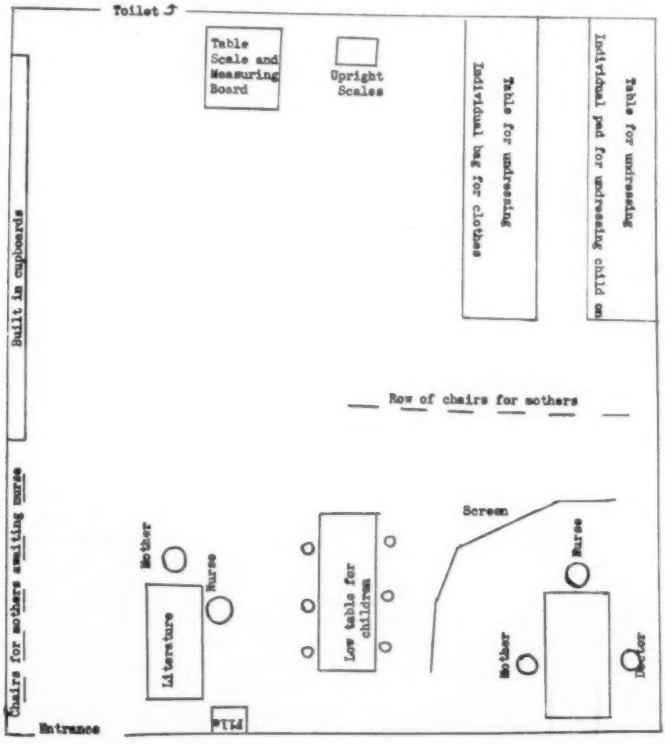
A table with baby scales and measuring board occupies the opposite corner of the room with fresh piece of paper for each infant. A demonstration layette is hung on wall

above this table, and the volunteer's desk is convenient to the table. A basinette completes this corner. This is used in case the mother has twins and wishes to park one of them while she is caring for the other, or in case a mother wishes to have a safe place to put her baby while she is taking care of the preschool child.

A box of ideal baby shoes and preschool clothes are placed on a table, together with literature for both baby and preschool child. We use literature put out by the insurance companies, the Children's Bureau, the Food and Dairy Company, and the State. Pamphlets Nos. 42, 52, 54, and 63 issued by the Bureau of Home Economics of the United States Department of Agriculture give excellent suggestions for clothes for the preschool.

A supply closet and several benches complete the furnishings of the outer room, and a desk for the doctor, one for the nurse, extra chairs, running water, and a cupboard for the nurse's clothes make up the small adjoining room.

*Houston:* Tables, chairs, scales (infant and adult), chairs for adults, small chairs for children, prenatal and child health literature, pamphlets on prevention of disease, etc.




*Typical and practicable arrangement of floor space*

*Minneapolis:* Waiting room: Practically all furniture belongs to settlement house. All tables covered with white oilcloth during clinic. The weighing table is placed conveniently near the light, and is large enough for 2 volunteers to work comfortably side by side.

The scales (metric system) belong to Infant Welfare Society. On the weighing table are writing materials, the charts of those children due at clinic, new weight books for children coming for first time, chart for volunteers (grams to pounds and ounces). A small table placed in quiet isolated corner with tray with applicators, fresh water and waste receiver, ready for mothers to wash breasts before nursing.

Posters: Every clinic has two issued from central office; every clinic has one bulletin board and a large 6-foot frame with poster which is changed every 2 months. Other posters are used from time to time.

Equipment also includes large wooden blocks (mill ends) in box with castors; platform scales for older children; one or two other long tables on which mothers can undress babies; and instruction tables (2) placed in quietest corners, yet convenient, having writing materials, weight books for return dates, patterns, diet cards and other literature necessary.

Clinic room contains the examining table and dictation table placed at end of examination table. On the latter are writing materials; chart of abbreviations for volunteers; return dates available; and charts in order.

*San Francisco:* In general set-up as outlined in N.O.P.H.N. manual.

*Syracuse:* Equipment: Registration desk, 2 chairs; pen, ink, blotters, clips, colored flags (red, black, blue, green); record file; new records; preschool weight books; literature issued by Syracuse Department of Health; New York State Program Cards, 1-2 Years, 2-4 Years, 2-6 Years; Metropolitan Life Insurance Company, "Out of Babyhood into Childhood"; John Hancock Life Insurance Company, "Between Two Years and Six."

Table for undressing equipped with children's robes; cotton pads, rubber sheeting, tissue paper; bags for clothing for mothers not bringing their own; waste paper basket.

Table for weighing equipped with pen, ink, blotter; scales with basket; upright scales; cotton pad and rubber sheets for scales; cotton pad and rubber sheets for table; measuring board and pad; tissue paper for scales, table, and board; waste-paper basket.

Row of chairs for mothers near physician's table.

### III. DOCTOR'S TABLE

*Brockton:* Writing supplies, height and weight charts, throat sticks, paper bags for waste, and blank records.

*Charleston:* Flat-top desk having in addition to the usual equipment, 2d year and 2 to 6 year diet lists; prescription blanks, and other printed routines which may be used by the physician. The examining table large enough for an adult is placed directly under two large windows, on the window-sills of which are pamphlets on infant and preschool care, breast-feeding, sunbaths, etc., together with a tray holding bottles of alcohol, boric acid solution, acetone, thermometers, cotton swabs, tongue depressors and applicators, tape measure, flashlight. Over the hand basin is liquid soap container. Paper towels are used. The table is protected by rubber-covered pad and sheets. Small pads and paper towels are used to protect large pad.

*Hartford:* Throat sticks, diet slips, towels, and a firm stool about a foot high for the child to stand on in front of the doctor.

*Houston:* Scissors, scalpel, forceps, small basins, trays, applicators, tongue blades, dressings, mercurochrome, iodine, argyrol crystals, etc.

*Minneapolis:* Pad; fresh paper tray covers; thermometer; alcohol; vasoline; cotton pledgets; adhesive; benzine; scissors; tongue blades in glass jar; tape measure; silver nitrate sticks.

*San Francisco:* We use an examining table especially designed by our director of field nurses which we find particularly satisfactory. It is 42¾" by 22½" with three sides built up to prevent the child from rolling. The yard stick for measuring is set in flush with the table top. It has on the end to the doctor's left, a smooth iron rod attached in such a way that the tissue paper used between cases can be easily slipped on and off. The table is covered with a thin rubber pad, over which a small sheet is tucked and over this the tissue paper, the latter being changes between cases. Large sheets of wrapping tissue are used.

*Syracuse:* Pen, ink, blotters; appointment file, extra cards (dated); notes to physicians and stamped envelopes; cotton pad, rubber sheet, tissue paper, water, soap, towels; alcohol; cotton in jar; wooden tongue depressors; bag for waste; waste basket; the physician supplies instruments.

*(To be continued in September)*

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**If sufficient requests for copies of this preschool conference material are received, reprints will be made available at cost to our readers. Reprints will be available, also, of Miss Kirkcaldy's article (page 386) which is a revision of her original material published in 1925 by the Visiting Nurse Association of Chicago.**

# NEWS NOTES

Through the interest and generosity of the Massachusetts Institute of Technology at Cambridge, Massachusetts, three public health nurses have been awarded scholarships in Health Education for the academic year 1931–32. The three who received the scholarships are Gertrude Deutsch, Instructor in Health Education at the Monmouth Normal School, Monmouth, Oregon, who was granted the award through the N.O.P.H.N.; Norma Van Druten, Red Cross Public Health Nurse in Santa Cruz County, California, who received the scholarship awarded by the Institute to any applicant from any source; and Theda Waterman, Executive Secretary of the Lake County Tuberculosis Association, Illinois, who received the award offered through the National Tuberculosis Association. The applications and credentials of all three were secured through the N.O.P.H.N.

The scholarships provide the tuition for an academic year's work at the Massachusetts Institute of Technology, and the program of study includes courses in Health Education, Public Health Administration, Principles of Teaching, etc.

The N.O.P.H.N. is exceedingly proud not only of its three representatives who received the awards but also of the other candidates for the scholarships who received consideration because of their favorable credentials, but lacked the unusually fine educational preparation and experience of the others. It is particularly encouraging to see the increasing interest that is being shown by nurses in the field in post-graduate study and we are exceedingly grateful for the opportunity that the Massachusetts Institute of Technology is offering to the public health nursing group.

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Miss Elnora Thomson, Director of the Public Health Nursing Course of the University of Oregon, and President of the American Nurses' Association, sailed in June for Europe, where she will attend the interim meeting of the International Council of Nurses. Miss Thomson will also attend the dedication of the right wing of the Florence Nightingale Memorial School of Nursing at Bordeaux, France, in memory of the American nurses who died during the World War. Funds for the building of this memorial have been contributed by American nurses.

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Announcement is made by Judge Max Huber, President of the International Committee of the Red Cross, of the award by that body of the Florence Nightingale medal and diploma to Elizabeth Gordon Fox, R.N., Executive Director of the Visiting Nurse Association of New Haven, Conn., and formerly National Director of the Public Health Nursing Service, American Red Cross. Although created in 1912, and heretofore awarded to 11 American nurses, this medal has never before been given for an outstanding contribution to the peace program of a Red Cross Society.

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The New York State nursing organizations will hold their 30th Convention at the Hotel Pennsylvania, New York City, October 20–22. The names of hotels situated near the Pennsylvania Hotel, and rates may be secured from the Hospitality Committee of the New York State Nurses Association, 450 Seventh Avenue, New York City.

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An Industrial Relations Congress, under the auspices of the International Industrial Relations Association, will be held in Amsterdam, August 23 to 29. The special topic of the congress is "Social Economic Planning—the necessity for planned adjustment of productive capacity and standards of living," in view of the widespread unemployment throughout the world. Further information may be obtained from Miss Mary Van Kleeck, Vice-President, International Industrial Relations Association, 130 East Twenty-second Street, New York City.

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## THE YOSEMITE MEETING

Report of the Western Conference of the American Nurses' Association, Yosemite Valley, June 5–7, 1931:

Some ninety nurses from eleven western states were present at these meetings, which were arranged as round tables in the mornings and general sessions in the afternoons when the conclusions of the morning were presented.

There were two round tables on public health nursing—one on "How Public Health Nurses May Use Lay Groups," the other on "Planning a Balanced Public Health Nursing Program." In addition, the round table on "Hourly Appointment Service" was of interest to public health nurses.

The conclusions from the round table on lay participation in public health nursing follow:

The need and value of lay participation and lay committees in public health nursing service, whether that service is under official (public) or non-official (private) auspices, were recognized.

The need of a change in attitude on the part of the nurses themselves toward the value and use of lay people was stressed. Means toward this end: More articles in professional magazines on lay accomplishments, inclusion of experienced laymen as speakers on state and local programs, lay institutes, use of laymen on committees.

It was agreed that the lay group has certain duties and responsibilities which the technical worker should not assume in establishing a well-rounded service, and that it is important to make a careful selection of the layman in relation to cross-section representation of the community, the kind of job to be done and the fitness of the layman for the job. Public health nurses should learn how to present their work in terms easily understood by the layman.

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## GOOD NEWS

Splendid news comes from the Board of Directors of the Commonwealth Fund! A grant of $25,000 has been made to the National Organization for Public Health Nursing to finance a study of the present administration and practice of public health nursing. Certain standards as to organization and content—qualitative and quantitative—in reference to public health nursing have been developed by the N.O.P.H.N., and particularly on the quantitative side by the A.P.H.A. These are generally accepted as goals, but it is not known to what extent such standards are actually in operation throughout the country. Some evaluation of our present development in public health nursing as measured by these standards seems important. This evaluation may reveal that some of the standards themselves need revision.

The study will cover both rural and urban services under official and non-official administration in different sections of the country. It is expected that the findings will serve as

A basis for necessary revision of present standards—

A basis for the consideration of problems for which no standards have been evolved as yet.

Every public health nurse and public health nursing organization will rejoice with the N.O.P.H.N. that this long contemplated and much needed study is to materialize at last.

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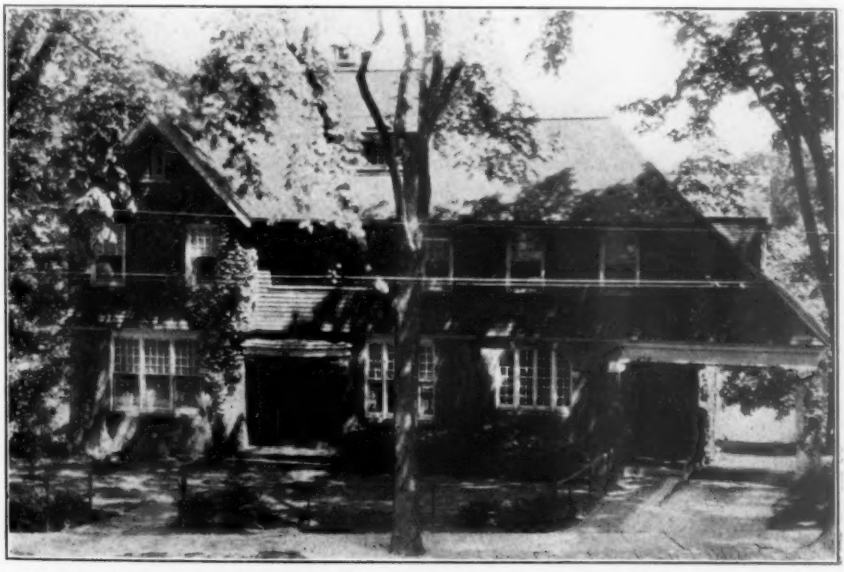

*The new headquarters of the Visiting Nurse Association, New Britain, Connecticut*